101-30

FISCAL YEAR 1990 BUDGET ISSUES RELATING TO PHYSICIAN INCENTIVE PAYMENTS BY PREPAID HEALTH PLANS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

APRIL 25, 1989

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FISCAL YEAR 1990 BUDGET ISSUES RELATING TO PHYSICIAN INCENTIVE PAYMENTS BY PREPAID HEALTH PLANS

TUESDAY, APRIL 25, 1989

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:09 a.m., in room 1100, Longworth House Office Building. Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
WEDNESDAY, APRIL 19,1989

PRESS RELEASE #11
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON FISCAL YEAR 1990 BUDGET ISSUES RELATING TO PHYSICIAN INCENTIVE PAYMENTS BY PREPAID HEALTH PLANS

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on fiscal year 1990 budget issues relating to physician incentive payments by prepaid health plans, such as health maintenance organizations (HMOs). The hearing will be held on Tuesday, April 25, 1989, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

In announcing the hearing Chairman Stark said: "Our health care delivery system depends on the trust patients place in their physicians. Incentive payments to physicians raise the possibility that that trust may be misplaced if the amount or type of services patients receive is dictated by economic considerations, rather than need."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

A 1986 report by the General Accounting Office (GAO) indicated that some hospitals were paying physicians incentives to reduce services to hospitalized Medicare payments. Based, in part, upon GAO's finding that such payments could lead to inappropriate reductions in service, the Omnibus Reconciliation Act of 1986 (OBRA '86) prohibited hospitals from making incentive payments to physicians.

HMOs were exempted from the prohibition on incentive payments until April 1, 1990.

OBRA '86 required the Secretary of Health and Human Services to report to the Congress by January 1, 1988, on physician payment arrangements used by HMOs. That report has not been received by the Committee at this time.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, May 5, 1989, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

*****

Chairman STARK. The Health Subcommittee of the Ways and Means Committee will begin a hearing on fiscal year 1990 budget issues with special emphasis on physician incentive payments by prepaid health plans such as health maintenance organizations.

Our health care delivery system depends on the trust patients place in their physicians. Incentive payments to physicians raise the possibility that that trust may be misplaced if the amount or type of services patients receive is dictated by economic considerations rather than need.

This is an issue which has concerned the subcommittee for some time, and we have taken a variety of actions in an effort to deal with potential conflicts of interest in physician decisionmaking.

Based on the view that such payments could lead to inappropriate reductions in service, I supported legislation, incorporated in the Omnibus Budget Reconciliation Act of 1986, which prohibited hospitals and HMO's from making incentive payments to physicians.

Given concerns about the impact on many physician payment arrangements in use by some HMO's, they were exempted from the prohibition until April 1, 1990.

We will hear testimony from the General Accounting Office and the Physician Payment Review Commission, both of which have devoted significant effort to this important issue.

Basing scientific issues about medical services for an individual patient on economic considerations will erode the trust in ethical professional judgment on which our health care delivery system rests. I continue to be concerned that physician incentive payments which reward physicians individually or in small groups for reduced levels of services to individual patients may lead to inappropriate reductions.

As in the case of referrals by physicians to facilities in which they have an ownership interest, we must create standards for physician incentive payments which guard against both the fact and appearance of impropriety.

I would further state at this time that I think time may cure a lot of this as we gain some experience. But when we have had almost 25 or 30 years of utilization review to cut down on overutilization, the bureaucracy and indeed this committee is somewhat unatuned to the idea of how we regulate underutilization.

And while I think we must indeed allow a fair way for people to share in the profits of their enterprise, writing a law that takes all of this into account has proven a lot more difficult than articulating what the problem is. I look forward to help from our witnesses today. Our first witnesses comprise a panel and will present two analyses to the physician incentive payment issue: Sarah F. Jaggar, the Director of Operations and Human Resources Division of the GAO; and representing the Physician Payment Review Commission, Dr. Karen Davis, a member of the Commission, and Chair of the Department of Health Policy and Management at Johns Hopkins University.

If you would both come forward, we will hear from you in the order in which you appear on the witness sheet.

As with all witnesses today, the prepared remarks, without objection, will appear in the record in their entirety. And we would urge

you to expand on, paraphrase, edit, or enlighten us about your testimony in any way you are comfortable.

Mr. Gradison.

Mr. GRADISON. No statement, Mr. Chairman, thank you.

Chairman STARK. Thank you.

Ms. Jaggar, would you proceed?

STATEMENT OF SARAH F. JAGGAR, DIRECTOR FOR OPERATIONS, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY THOMAS DOWDAL, ASSISTANT DIRECTOR, AND ROGER HULTGREN, EVALUATOR

Ms. JAGGAR. Thank you, Mr. Chairman.

I am pleased to be here today to discuss our recent report prepared at your request entitled "Medicare: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care."

With me today are Mr. Tom Dowdal, on my left, and Mr. Roger Hultgren, who had primary responsibility for our work in this area.

In your request, you asked us to review incentive plans and to identify features that pose the greatest potential threat to quality of care. In summary, we identified four incentive plan characteristics that singly, or in combination, may pose a threat to quality of care, and suggest that if the subcommittee considers modification to the prohibition of incentive payments by prepaid plans, it should also consider retaining a ban on plans that closely link financial rewards to individual treatment decisions, or expose primary care physicians to substantial financial risks for services provided by other providers.

The prohibition against using incentive payments to physicians by HMO's with Medicare risk contracts takes effect, as you know, April 1, 1990. Let me briefly begin with a little background information.

Medicare beneficiaries obtain physician services through two basic systems. Under one system, the fee-for-service system, physicians charge for each service they perform and are reimbursed on a unit of service basis. Under this system, there is no financial incentive for physicians to control program costs because the more services the physician furnishes, the greater the physician's income.

The second way beneficiaries receive services is through enrollment in an HMO, or a prepaid health plan. HMO's receive a predetermined fixed monthly fee paid in advance, a capitation payment. In return, the HMO provides directly or arranges and pays for health care for a voluntarily enrolled population. Enrollees receive services from physicians who are employees of or contractors with HMO's.

Because the HMO assumes responsibility for providing services within a fixed amount, it has a financial incentive to minimize the use of health services. All other things being equal, the fewer services the HMO provides, the more money from the fixed capitation fee it retains as profit.

HMO's commonly use three basic compensation arrangements for their physicians: salaries, fee-for-service and capitation under

which physicians are assigned specific HMO enrollees and accept a monthly amount as payment in full for each assigned member regardless of how many services the member received during the last month.

Under these last two arrangements, physicians share the risk for the cost of operating HMO's. Medicare risk contracts are common vehicles used by HMO's. As of April 1989, about 1.1 million Medicare enrollees were covered under 133 such risk contracts. Medicare pays an HMO 95 percent of the amount the program estimates it would pay per beneficiary under the fee-for-service system in an HMO's service area. The HMO has a financial incentive to constrain costs because it may keep any profit from its Medicare risk contract that does not exceed its estimated profit rate on its private lines of business.

Moving now to some of the specifics of our study, I would like to talk about HMO financial arrangements. Our December 1988 report presented the results of our review of the physician incentive arrangements used by 19 HMO's in the States of California, Florida, Minnesota and Pennsylvania. These HMO's had about 44 percent of all Medicare HMO enrollees as of May 1988, about 438,000 Medicare enrollees.

The 19 HMO's had a variety of physician compensation methods. Four used salaried physicians; four paid physicians on a fee-for-service basis, and 11 used capitation systems with coverage ranging from only primary care to all health services. The specifics of the 19 HMO physician incentive plans also varied considerably. For example, two HMO's did not have incentive plans while one HMO used capitation to shift the financial risk for all health services to primary care physicians. Between these extremes, virtually every conceivable combination of risk-shifting and cost-performance evaluation period was represented.

Our review of the physician incentive plans identified four characteristics that we believe, singly or in combination, could tend to give physicians too strong an incentive to reduce services and, thus, could adversely affect quality of care for Medicare patients.

Those characteristics are: First, the amount of risk shifted from the HMO to physicians. Second, the number of physicians whose cost performance is used to decide the amount of the incentive funds available for distribution.

Third, whether incentive payments are based on a percentage of HMO savings or profits, and Fourth, the length of time over which cost performance is measured.

Let me briefly discuss each of these four characteristics.

Under arrangements where HMO risk is shifted to the physicians, they are liable for providing or paying for needed services, either directly from the physician's payment from the HMO or from funds withheld from the physician's compensation. Shifting risk to physicians can place them in a compromising position when treating potentially expensive cases. If the HMO physician must pay for specialty or institutional services out of his or her own group's account, the physician has an incentive not to order such services.

The second characteristic is one where incentive payments are based on the performance of individual physicians causing a rela-

tively higher potential to adversely affect the quality of care than do plans where the size of the incentive payment is based on the performance of a group. Furthermore, the larger the group whose performance determines the amount of the incentive payment, the less likely it is that there will be an adverse effect on quality. The main concern here is the immediacy of the linkage between treatment decisions and an incentive payment.

The third characteristic that may threaten quality of care is whether the HMO pays its physicians a percentage of plan savings. Under this arrangement, the fewer treatments provided, the higher the potential incentive payment to physicians. The pull of this incentive would be greater if the plan linked incentive payments to savings on an individual physician's payment versus savings on a group of physicians' patients, or if the payments were computed on savings or profits over a short period of time rather than a relatively long period.

Fourth on our list is the length of time over which performance is measured. Basing incentive payments on physician cost performance over a short period of time, such as a month, may increase the temptation to underprovide services.

In conclusion, the primary purpose of HMO physician incentive plans is to get physicians to consider that cost implications of diagnosis and treatment alternatives. The goal of such plan should be to encourage physicians to select the least expensive course of care that meets the patient's needs and results in adequate care. However, singly or in combination, certain HMO incentive plan features have a higher potential than others to encourage physicians to inappropriately limit services. HMO's that place physicians directly at risk, or that withhold physicians' compensation and place it at risk, for specialty or hospital expenses, without limiting their financial liability, could result in the diminution of patient care. Also, arrangements in which incentive funds are distributed based on individual physician performance, cost performance over a short period of time, or a portion of the HMO's profits or savings cause concern.

We believe that the stronger the financial incentive to reduce the costs of care, the stronger the mechanisms that should be in place to prevent and identify inappropriate reductions in services. Medicare law already requires HMO's to have quality assurance and utilization review programs, systems to check on physician credentials, and grievance procedures to help assure that beneficiaries receive quality care. Thus, the question becomes how effective are those systems in counterbalancing the incentives of financial incentive plans?

We believe that as the subcommittee considers modifications to Medicare to permit certain HMO physician incentive payments, it also should consider retaining a ban on arrangements that closely link financial rewards with individual treatment decisions and/or expose the primary care physicians to substantial financial risk for services provided by physicians or institutions to whom he or she refers patients for diagnosis or treatment.

Mr. Chairman, this concludes my prepared remarks. We will, of course, be happy to answer any questions you may have.

[The statement of Ms. Jagger follows:]

STATEMENT OF SARAH JAGGAR, DEPUTY DIRECTOR FOR OPERATIONS, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the report we prepared at your request concerning incentive arrangements between certain prepaid health plans and the physicians who provide health care services to plan members.[1]

Beginning April 1, 1990, current law prohibits physician incentive payments by prepaid health plans with Medicare risk contracts. When enacting this prohibition, the Congress directed the Department of Health and Human Services to study the incentive plans offered by prepaid health plans and recommend to the Congress exceptions to the prohibitions for incentive plans that do not have a substantial potential for adverse effects on quality. The Subcommittee asked us to review plans with a view toward identifying features that are most problematic from a quality-of-care standpoint.

Our report identified four incentive plan characteristics that singly or in combination may pose a threat to quality of care. Essentially, the troubling nature of these characteristics revolves around two key issues: (1) the closeness of the linkage between a physician's treatment decisions and payment of an incentive and (2) the amount of financial risk transferred from the health plan to the physician. We suggested that if the Subcommittee considers modifications to the prohibition of incentive payments by prepaid plans, it also should consider retaining a ban on plans that closely link financial rewards to individual treatment decisions or expose primary care physicians to substantial financial risk for services furnished by other providers or both.

BACKGROUND

Medicare is the federal health insurance program for Americans age 65 and older and certain disabled persons. The program covers a broad range of health services for its 33 million beneficiaries. Medicare part A, hospital insurance, covers inpatient hospital, skilled nursing facility, hospice, and home health care. Part B, supplementary medical insurance, covers many types of noninstitutional services, such as physician, clinical laboratory, X-ray, and physical therapy services.

Medicare beneficiaries obtain physician services through two basic systems. Under one system, called fee-for-service, physicians charge for each service they perform and are reimbursed on a unit-of-service basis. Under this system, there is no financial incentive for physicians to control program costs because the more services a physician furnishes, the greater the physician's income.

The second way beneficiaries receive services is through enrollment in a prepaid health plan, specifically health maintenance organizations (HMOs) and competitive medical plans.[2] HMOs receive a predetermined, fixed monthly fee paid in advance (that is, a capitation payment). In return, the HMO provides directly or arranges and pays for health care for a voluntarily enrolled population. Enrollees receive services from physicians who are employees of or contractors with HMOs. Because the HMO assumes responsibility for providing services within a fixed amount, it has a financial incentive to minimize the use of

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[1]Medicare: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care (GAO/HRD-89-29, Dec. 12, 1988).

[2]HMO will be used to refer to both HMOs and competitive medical plans. While subject to essentially the same Medicare regulatory requirements as HMOs, competitive medical plans have greater flexibility than federally qualified HMOs in setting their commercial premium rates and types of service covered.

health services. All other things being equal, the fewer services the HMO provides, the more money from the fixed capitation fee it retains as profit.[3]

HMOs commonly use three basic compensation arrangements for their physicians:

-- Salary. Under this arrangement, the physician's income may be tied to factors such as training, experience, performance, or tenure; it is not related to utilization of services. Salaried physicians have minimal financial risk for utilization and have few financial incentives to control service utilization.

-- Fee-for-service. As in the traditional fee-for-service system, physicians affiliated with HMOs that use the fee-for-service approach are paid per unit of service, with modifications to encourage utilization control. The HMO may pay physicians' actual charges, prevailing charges in the area, or an amount based on a fee schedule. Physicians may share in the HMO's financial risk by having part of their payments withheld in a risk pool that is distributed to the physicians only if the HMO's total costs do not exceed specified levels.

-- Capitation. Under this approach, physicians are assigned specific HMO enrollees and accept a monthly amount as payment in full for each assigned member regardless of how many services the member receives during the month. Under capitation arrangements, an individual primary care physician can gain or lose depending on the frequency or extent of services provided to enrollees or both. Capitation arrangements can cover (1) primary care, (2) all physician services, or (3) all health services. Under the first arrangement, primary care physicians are responsible only for their own services. Under the second, physician service capitation, primary care physicians are responsible for both their services and for the cost of services provided by specialists to whom patients are referred. Under the third, health service capitation, primary care physicians are responsible for all covered health benefits for HMO members assigned to a physician's group.

MEDICARE RISK CONTRACTS

Because risk contracts offered the potential to constrain Medicare costs, the Congress modified Medicare's risk contract authority through the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Under TEFRA risk contracts, Medicare pays an HMO 95 percent of the amount the program estimates it would pay per beneficiary under the fee-for-service system in the HMO's service area. Under the TEFRA provisions, the HMO has a financial incentive to constrain costs because it may keep any profit from its Medicare risk contract that does not exceed its estimated profit rate on its private lines of business.

The first TEFRA risk contracts were signed in April 1985, and by April 1989, about 1.1 million Medicare enrollees were covered under 133 risk contracts.

PROHIBITIONS ON FINANCIAL INCENTIVES

Concerns about physician incentive plans surfaced in relation to plans offered by hospitals. In addressing the

[3]We use the term profit to refer to money the HMO may retain. Many HMOs are not-for-profit organizations, and for those HMOs, the term technically is "excess of revenues over expenses."

concerns, the Congress not only prohibited plans offered by hospitals but also by HMOs.

In July 1986, we reported that certain hospital plans offered financial incentives to physicians that could have a detrimental effect on the quality of care provided to Medicare patients.[4] One plan of particular concern included a combination of features that, taken together, could provide physicians too strong an incentive to undertreat patients. This plan distributed incentive funds monthly, based on each individual physician's performance in contributing to the hospital's revenues. Moreover, this plan did not contain control mechanisms, such as a quality review program, to prevent or identify abuses.

In the Omnibus Budget Reconciliation Act of 1986, the Congress prohibited, effective April 21, 1987, direct or indirect incentive payments by Medicare participating hospitals to physicians to reduce or limit services. The same provision also prohibited HMOs with Medicare (or Medicaid) risk contracts from making such incentive payments, effective April 1, 1989. The Omnibus Budget Reconciliation Act of 1987, extended the effective date for HMOs to April 1, 1990.

HMO FINANCIAL ARRANGEMENTS

Our December 1988 report presented the results of our review of the physician incentive arrangements used by 19 HMOs in the states of California, Florida, Minnesota, and Pennsylvania. These HMOs had about 44 percent of all Medicare HMO enrollees in May of 1988.

The 19 HMOs had a variety of physician compensation methods--4 used salaried physicians, 4 paid physicians on a fee-for-service basis, and 11 used capitation systems with coverage ranging from only primary care to all health services. The specifics of the 19 HMOs physician incentive plans also varied considerably. For example, two HMOs did not have incentive plans while one HMO used capitation to shift the financial risk for all health services to physicians. Between these extremes, virtually every conceivable combination of risk-shifting and cost-performance-evaluation period was represented by at least one of the HMOs.

Our review of the physician incentive plans identified four characteristics that we believe, singly or in combination, could tend to give physicians too strong an incentive to reduce services and, thus, could adversely affect quality of care for Medicare patients. Those characteristics are:

1. the amount of risk shifted from the HMO to physicians,
2. the number of physicians whose cost performance is used to decide the amount of the incentive funds available for distribution,
3. whether incentive payments were based on a percentage of HMO savings or profits, and
4. the length of time over which cost performance is measured.

Our rationale relates to two main factors that tend to increase the strength of financial incentives to reduce service provision:

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[4]Medicare: Physician Incentive Payments by Hospitals Could Lead to Abuse (GAO/HRD-86-103, July 22, 1986).

-- the immediacy of the financial reward to individual treatment decisions made by physicians and

-- the extent of financial risk transferred to physicians.

Plans that base their incentive payments on cost performance over relatively long periods of time for large numbers of enrollees served by a number of physicians would probably not provide strong financial incentives to underserve individual patients. On the other hand, the closer financial incentives are tied to individual treatment decisions and the more risk placed on the physician, the higher the potential for adverse effects on quality of care.

Under arrangements where HMO risk is shifted to the physicians, they are liable for providing or paying for needed services, either directly from the physician's payment from the HMO or from funds withheld from the physician's compensation. Shifting risk to physicians can place them in a compromising position when treating potentially expensive cases. If the HMO physician must pay for specialty or institutional services out of his or her own or group's account, the physician has an incentive not to order such services.

HMOs that base incentive payments on performance of individual physicians have a relatively higher potential to adversely affect quality of care than do plans where the size of the incentive payment is based on the performance of a group. Furthermore, the larger the group whose performance determines the amount of the incentive payment, the less likely adverse effects on quality will result. The main concern here is the immediacy of the linkage between treatment decisions and an incentive payment.

An individual physician is normally responsible for a limited number of patients. If a physician's incentive payment is based only on his or her own performance, the physician may be tempted to postpone or withhold treatment when faced with a potentially expensive case. If, on the other hand, a physician's incentive payment is based on the performance of a group of physicians, with a larger pool of patients over which to spread treatment costs, the more remote individual treatment decisions become from the amount of payment received. This also makes it less likely that the incentive plan will cause a reduction in quality of care.

The third characteristic that may threaten quality of care is whether the HMO pays its physicians a percentage of plan savings. Under this arrangement, the fewer treatments provided, the higher the potential incentive payment to physicians. The pull of this incentive would be greater if the plan linked incentive payments to savings on an individual physician's patients versus savings on a group of physicians' patients, or if the payments were computed on savings or profits over a short period of time rather than a relatively long period of time.

Fourth on our list is the length of time over which performance is measured. Basing incentive payments on physician cost performance over a short period of time, such as a month, may increase the temptation to underprovide services. With brief performance periods, the effect of treatment decisions on the amount of incentive payment is always short term. Thus, if physicians know that every month or so they will be rewarded for holding down treatment costs, they may be more concerned about the effect that each patient's treatment cost has on incentive payments than if rewards are based on longer periods of performance measurement.

In addition to increasing the incentive for physicians to underserve beneficiaries, short performance periods may encourage physicians to delay care for beneficiaries needing costly treatment. Delays in obtaining care may encourage beneficiaries to disenroll from the HMO. If a beneficiary were to disenroll before receiving needed expensive services, the physician could be eligible for a larger incentive payment than if the beneficiary remained in the HMO.

CONCLUSIONS

The primary purpose of HMO physician incentive plans is to get physicians to consider the cost implications of diagnosis and treatment alternatives. The goal of such plans should be to encourage physicians to select the least expensive course of care that meets the patient's needs and results in adequate care. However, singly or in combination, certain HMO incentive plan features have a higher potential than others to encourage physicians to inappropriately limit services. HMOs that place physicians directly at risk, or that withhold physicians' compensation and place it at risk, for specialty or hospital expenses or both without limiting their financial liability could result in the diminution of patient care. Also, arrangements in which incentive funds are distributed based on individual physician performance, cost performance over a short period of time, or a portion of the HMO's profits or savings cause concern.

The stronger the financial incentive given to physicians to reduce the costs of care, the stronger the mechanisms that should be in place to prevent and identify inappropriate reductions in services. Medicare law already requires HMOs to have quality assurance and utilization review programs, systems to check on physician credentials, and grievance procedures to help assure that beneficiaries receive quality care. Thus, the question becomes: How effective are those systems in counterbalancing the incentives given physicians by financial incentive plans? This is difficult to answer. Our review of the literature and discussions with federal and private health care experts did not identify any studies directly assessing the effect of HMO physician financial incentive plans on quality of care that would help to answer it.

In conclusion, we believe that if the Subcommittee considers modifications to Medicare to permit certain HMO physician incentive payments, it also should consider retaining a ban on arrangements that closely link financial rewards with individual treatment decisions or expose the primary care physician to substantial financial risk for services provided by physicians or institutions to whom he or she refers patients for diagnosis or treatment or both.

Mr. Chairman, this concludes my prepared remarks. I will be happy to answer any questions you may have.

Chairman STARK. Thank you very much.
Ms. Davis.

STATEMENT OF KAREN DAVIS, PH.D., COMMISSIONER, PHYSICIAN PAYMENT REVIEW COMMISSION (PPRC), AND CHAIR, DEPARTMENT OF HEALTH POLICIES AND MANAGEMENT, JOHNS HOPKINS UNIVERSITY, ACCOMPANIED BY PAUL GINSBURG, PH.D., EXECUTIVE DIRECTOR, AND JANET CORRIGAN, PH.D., SENIOR ANALYST

Ms. DAVIS. Thank you, Mr. Chairman, members of the committee.

I am accompanied by Dr. Paul Ginsburg, Executive Director of the Physician Payment Review Commission, and Janet Corrigan, a Senior Analyst for the Commission.

We appreciate the opportunity to testify on behalf of the Physician Payment Review Commission on the provision of financial incentives to physicians by HMO's and competitive medical plans with Medicare risk contracts.

The way in which a physician is paid may influence both the acceptability and quality of patient care as well as costs. The Commission's annual report to Congress to be transmitted at the end of this week includes a full discussion of this issue with recommendations, which I am pleased to share with you today.

With current arrangements, there is concern that some prepaid plans place physicians at too great a degree of risk for the costs of care. The Medicare prepaid health care program was not intended to transfer risk from Medicare to individual physicians or small groups of physicians, but rather to prepaid plans. Risk-sharing arrangements should not be used to compensate for ineffective organization and management of HMO's. If financial incentives to physicians are too great, and if substantial risk is transferred to individual physicians or small groups, unacceptable barriers to access could result.

Concern about the impact of financial incentives on patient care is greatest when capitation is the basic method of payment for the primary care physicians. This is of particular concern if the primary care physician's capitation includes incentives for specialty services and hospital care.

Another basis for concern about capitation of individual physicians is its extensive use by a form of HMO and competitive medical plan called an independent practice association or IPA. IPA's often lack formal and informal peer review mechanisms. Their pattern of delivering care is much more decentralized, many of their physicians care for HMO patients in private practice settings and, therefore, formal quality assurance programs are less effective. They also rely upon the physician's individual medical record system which may vary from physician to physician.

IPA's enable beneficiaries, however, to enroll in an HMO without severing their established ties with their physician.

In view of these concerns, we do think that some steps are necessary. However, at the present time, we have no definitive information about whether or not risk-sharing arrangements may have an adverse effect on access or quality.

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Financial incentives do represent an important mechanism for controlling costs and increasing productivity. Any broad-based restrictions on risk sharing would likely result in a termination of many Medicare risk contracts. As Ms. Jagger mentioned, over a million Medicare beneficiaries now get care through Medicare HMO's, and many of these could lose access to care if one were to have very restrictive provisions.

HMO's do provide these beneficiaries with significant advantages, most notably reduced copayments and expanded benefit coverage. Therefore, we conclude that while the concern about the potential effects or misuse of financial incentives is appropriate, it would be wise to proceed cautiously in responding to this concern.

The best approach for Medicare would be to adopt limited restrictions on the use of financial incentives and strengthen its monitoring effort. Specifically, the Physician Payment Review Commission recommends six specific actions:

First, Medicare should require that prepaid plans limit the total risk assumed by individual physicians or small groups through some form of reinsurance or stop loss provision.

Second, Medicare should require all prepaid plans to rely primarily on incentives to groups of physicians rather than to individual physicians. Group-level risk-sharing arrangements weaken the effect of specific patient decisions on a primary care physician's personal income, and also encourage active peer review.

Third, prepaid plans should be required to disclose to both physicians and beneficiaries appropriate information on risk-sharing arrangements.

In addition to the above restrictions on financial incentives, Medicare should continue to strengthen its monitoring processes applicable to HMO's and competitive medical plans.

Medicare should also conduct periodic surveys of beneficiaries to ascertain their level of satisfaction with the accessibility and quality of patient care. And that applies to both beneficiaries who are served in the fee-for-service system as well as those who are served by HMOs so that we can have a basis for comparing patient accessibility and quality in the two systems of care.

Finally, the Health Care Financing Administration should place a high priority on research designed to assess the impact of alternative risk-sharing arrangements on patient care. As the chairman noted, we have a long experience with incentives and methods to try to reduce overutilization of services, but we need to learn much more about the effect of risk sharing arrangements to give physicians an incentive to reduce care, and look at their impact upon the accessibility, quality costs and efficiency of patient care received by beneficiaries.

Thank you. I will be happy to elaborate or answer any questions.

[The statement of Ms. Davis follows:]

Statement of the Physician Payment Review Commission
before the
Subcommittee on Health
Committee on Ways and Means
by
Karen Davis, Ph.D.
Commissioner

I appreciate the opportunity to testify on behalf of the Physician Payment Review Commission on the provision of financial incentives to physicians by HMOs and CMPs with Medicare risk contracts. This is an issue the Commission feels is very important. The way in which a physician is paid may influence both the accessibility and quality of patient care as well as costs. The Commission's annual report to Congress to be transmitted at the end of the week includes a full discussion and recommendations on this issue.

BACKGROUND

All methods of compensating physicians include financial incentives that may affect patient care. In general, the incentives inherent in fee-for-service are toward over-utilization. Capitation, which provides a predetermined, fixed payment to a physician to cover the costs of services needed by a beneficiary during some period, has an incentive towards underservice. Salary provides the most neutral incentives concerning the use of services, but in the absence of some additional payments such as bonuses, physicians on salary might be less productive and less responsive to patient needs.

Many prepaid health plans have developed physician compensation packages that attempt to neutralize any incentives toward over- or under-utilization that may be inherent in the basic method of payment. It is very common for prepaid plans that pay physicians on a fee-for-service basis to withhold a portion of each fee (typically 10 to 20 percent) to cover the costs of patient care that exceed the budget. Capitation payments to primary care physicians to cover services they directly provide are often accompanied by withholds for specialty or hospital care to balance the incentives for primary care physicians to substitute services outside the boundaries of the capitation payment for those inside. Physicians on salary frequently receive bonuses based on measures of productivity, resource use, and patient satisfaction.

In most prepaid plans, physician compensation packages are also designed to transfer from the plan to its physicians some of the risk for the costs of patient care. The distribution of risk across prepaid plans, physicians, and beneficiaries (through copayments) is based on the recognition that each influences the efficiency and outcomes of patient care, all play a part in determining total health care costs, and no one party feels able to shoulder the entire risk.

HMO efforts to design well-balanced risk-sharing arrangements are hampered by the absence of information on the effects of risk-sharing on provider behavior, by limited knowledge of patient characteristics that lead to differences in future costs and rudimentary models for adjusting payments to account for such differences, and by limited methods of measuring and evaluating physician performance. The lack of knowledge about physician compensation arrangements results in part from the HMO industry's state of rapid growth and flux. Over 63 percent of HMOs have been providing prepaid care for less than five years, and these young HMOs are highly diverse (InterStudy, Fall 1988). HMOs differ in ownership, management structure, practice setting, contractual arrangements with physicians and hospitals, and financial viability in addition to provider compensation arrangements.

CONCERNS ABOUT RISK-SHARING ARRANGEMENTS

With current arrangements, there is concern that some prepaid plans place physicians at too great a degree of risk for the costs of care. The Medicare prepaid health care program was not intended to transfer risk from Medicare to individual physicians or small groups, but rather to prepaid plans with the capability of underwriting insurance risk and establishing processes for monitoring and promoting the accessibility and quality of care. Risk-sharing arrangements should not be used to compensate for ineffective organization and management systems. If financial incentives to physicians are too great and if substantial risk is transferred to individual physicians or small groups, unacceptable barriers to access could result.

Concern about the impact of financial incentives on patient care is greatest when capitation is the basic method of payment of primary care physicians. The degree of physician risk is usually greater under capitation than fee-for-service or salary, and this is especially true when capitation payments are broadly defined to cover specialty services and hospital care in addition to services provided directly by the primary care physician and when the capitation payments are made to individual physicians or small groups.

Another basis for concerns about capitation of individual physicians is its extensive use by independent practice associations (IPAs).[1] IPA's often lack formal and informal peer review mechanisms to guard against inappropriate care. They are generally more decentralized than other HMOs and may have numerous contracts with individual physicians who care for HMO patients within private practice settings that afford limited opportunity for informal peer review. Formal quality assurance programs of IPAs may also be less effective than in other HMOs because of divergent medical record systems. On the other hand, by working with private practice physicians, IPAs enable beneficiaries to enroll in an HMO without severing established ties with their physician.

LIMITS ON MEDICARE'S OPTIONS

Although the impact of risk-sharing arrangements on patient care raises concerns, prohibiting such arrangements could not be in the best interest of Medicare beneficiaries. First, we have no definitive information concerning whether or not risk-sharing arrangements now have an adverse effect on access or quality. The relevant literature shows that, overall, HMOs provide care that is generally equivalent or superior in quality to that provided within the fee-for-service sector. Wide variations in medical practice have been documented in the fee-for-service sector, indicating areas for improving the appropriateness of medical care. If properly structured and integrated into an HMO's managed care environment having formal and informal peer review, physician risk-sharing may be an effective way to improve patient care.

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[1] In a survey of 173 member plans of the Group Health Association of America and the Blue Cross and Blue Shield Association, it was found that 44 percent of IPAs make capitation payments to individual physicians as compared with nine percent of mixed models, five percent of network models, five percent of staff models, and zero percent of group models (GHAA, January 1988; Gold and Reeves, 1987). More Medicare enrollees are in IPAs (45 percent) than in any other model, and IPAs account for about 58 percent of risk-based contracts (Office of Prepaid Health Care, March 1989). IPAs are also the most rapidly growing segment of the HMO market--IPAs constitute 86 percent of HMOs that are less than three years old (InterStudy, Fall 1988).

Second, the widespread adoption of risk-sharing arrangements by HMOs reflects their belief that financial incentives represent an important mechanism for controlling costs and increasing productivity. Many HMOs have failed financially, and the absence of strong incentives to physicians is frequently cited as a major factor. Attempts to modify physician practices using nonfinancial approaches such as education, information feedback and utilization review have enjoyed only limited success. Prohibition of risk-sharing arrangements could impair the financial viability of many plans.

Third, any broad-based restrictions on risk sharing would likely result in the termination of many Medicare risk contracts. Medicare is not a major third-party payer for managed care plans. Medicare recipients account for only a small fraction of total HMO enrollees, and only one out of five HMOs have Medicare risk contracts. If legislative prohibitions were imposed on risk-sharing arrangements, prepaid plans would have to decide whether to modify their compensation packages and risk higher costs, or terminate their Medicare contracts altogether. Beneficiary access to prepaid health care would be reduced.

Beneficiaries would lose if access to HMOs was reduced because many HMOs provide beneficiaries with significant advantages over the traditional fee-for-service system, most notably reduced copayments and expanded benefit coverage. In HMOs, beneficiary copayments for both ambulatory and inpatient services are either very low or nonexistent. Beneficiaries enrolled in HMOs generally also have expanded coverage for items such as prescription drugs, dental care, and home care.

Although the Commission believes that concern about the potential effects of financial incentives is appropriate, it would be wise to proceed cautiously in responding to this concern. It would be inappropriate at this time to subject HMOs to extensive restrictions that would hamper their efforts to provide comprehensive high quality services at a reasonable price.

THE COMMISSION'S RECOMMENDATIONS

The best approach for Medicare would be to adopt limited restrictions on the use of financial incentives and strengthen its monitoring effort. Specifically, the Commission recommends six specific actions.

First, Medicare should require that prepaid plans limit the total risk assumed by individual physicians or small groups through some form of reinsurance or "stop loss" provision. Reinsurance generally protects the physician against the costs of care associated with catastrophic cases, thus reducing the likelihood of a physician incurring large financial losses that may result in financial insolvency or underservice of beneficiaries.

Second, Medicare should require all prepaid plans to rely primarily on incentives to groups of physicians rather than to individual physicians. Group-level risk-sharing arrangements weaken the effect of specific patient decisions on a primary care physician's personal income, and also encourage active peer review.

Third, prepaid plans should be required to disclose to both physicians and enrollees appropriate information on risk-sharing arrangements. Informed and knowledgeable physicians and beneficiaries could facilitate the prevention or early identification of any inappropriate care that may result from financial incentives.

In addition to the above restrictions on financial incentives, Medicare should continue to strengthen its monitoring processes

applicable to prepaid plans. Increased monitoring is desirable regardless of the degree of financial risk assumed by physicians because monitoring systems identify a variety of access and quality problems including those that may result from risk-sharing. The Commission endorses comprehensive monitoring of the structural aspects of prepaid plans and supports the Office of Prepaid Health Care's efforts during the last year to improve the HMO monitoring program. But it continues to be concerned about the proliferation of federal, state, and private monitoring programs and requirements, and urges a coordinated approach to the development of standards and their monitoring.

Medicare should also conduct periodic surveys of beneficiaries to ascertain their level of satisfaction with the accessibility and quality of patient care. It is not recommended that survey information specific to individual prepaid plans be collected--the costs of which would be prohibitive. But beneficiaries enrolled in both the capitated and fee-for-service sectors should be included in the survey so that potential problems associated with alternative types of delivery systems may be identified.

Lastly, HCFA should place a high priority on research designed to assess the impact of alternative risk-sharing arrangements on patient care, and to develop better methods of designing compensation systems for physicians. It is important to identify the effect of risk-sharing arrangements on the accessibility, quality, cost, and efficiency of patient care received by beneficiaries. This research could focus on such factors as individual versus group-level incentives, size of the physician group, magnitude of total risk assumed at the individual and group-levels, and incentives applicable to hospital and specialty care. Research is also needed to identify the effects of patient characteristics on the use of services and to develop better methods of adjusting compensation arrangements for differences in risk attributable to patient characteristics. A better understanding of issues related to the design and effects of risk-sharing arrangements would provide a foundation for making future policy decisions, and assist HMOs in fashioning well-balanced risk-sharing arrangements that encourage efficient behavior and cooperation on the part of payers, providers, and beneficiaries in the use of resources.

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Chairman STARK. Thank you.

This problem is still kind of vexing.

I'm unsure as to whether we should approach this and draft something that tries to outline the spirit of the law, or why do we have to concern ourselves with a lot of details that get down to the letter of the law?

Watching what's happened in the cornership on the referral business where the spirit of the law is pretty broad, and the Medicare, there's a whole lot of letters of the law that are being created that seem to get around that. I prefer to see it as the spirit of the law and let you all at HCFA come out with regulations. I don't know how that will work.

Karen, in your statement here, would you require a stop-loss provision? Would you also say that any contracts therefore ought to have a minimum income to the doctor, even in another HMO situation where there's a salary plus bonus or a salary plus sharing? That the contracts ought to prohibit the doctor's income from diminishing below some amount if, in fact, there is too high a loss because of specialty procedures? Would that stop-loss provision include a stop down to the level of the individual physician?

Ms. DAVIS. Well, I do think that one needs to be concerned how much of the incentive the individual physician has and how much of their income derives from the incentive plan versus their base compensation.

Chairman STARK. Well, what I am suggesting is that there ought not to be a negative or a disincentive. In other words, you work for $5,000 a month minimum plus some share in the profits of the enterprise, don't you think we ought to prohibit fines? In a sense saying if you refer too many days in the hospitals, we're going to dock you a hundred bucks for every extra day? Ought that not to be in the same category as your stop-loss provision for the group?

Ms. DAVIS. Right. So that if you have a primary care physician who is paid, say, on a fee-for-service or salary, or a primary care capitation rate, then they might get a share of the savings from the experience of the specialty referral fund.

Chairman STARK. But not a share in the loss?

Ms. DAVIS. Not a share in the loss. And something like a 10 percent increment to their base income from that incentive tied to the experience with the specialty referral fund.

Chairman STARK. The idea was brought up earlier in the testimony. Are you suggesting, Ms. Jaggar, that you don't want immediate payment or immediate gratification? In other words, if I—at the end of the month, if I've hit some target for that month, you think it would be simpler if I had to wait until the end of the year? Therefore, there is not this Pavlovian linkage between sending somebody to the hospital and getting a hundred bucks in my pocket? Is that the idea, to spread the time out and, therefore, there will be less immediate reaction?

Ms. JAGGAR. Behavioral research has shown that the closer the reward is to the action, the more likely you are to take the action. And, of course, if our objective is to assure quality of care, we don't want physicians to be tempted, shall we say, because it might be close to the end of the month, to delay treatment or in any other

way not provide those services which would be in the best interest of the patient.

Chairman STARK. I will refrain from drawing all the conclusions for as long as I can about that. But that's what I thought you had in mind.

Is this just oversimplifying odds by the witness? It just seems to me that if you could say, look, the doctor can share in the profits of the enterprise, but the minute you can identify a single doctor's action resulting in a payment—in other words, if at the beginning of the time period, you decide that there are six of you at the witness table and each of you is going to get a sixth of whatever profit there might be at the end of this quarter or 6 months from now, or a year from now, that's the deal? Then you all go ahead and practice and do what you do. You share at the end of that period, but no special bonuses for you or you depending on how many x rays you order or don't order. Then as long as the group is big enough, which I guess could be another little problem, you don't carve me up into several groups. I am certainly not just one part of one HMO, I'm part of a primary care HMO and a surgical HMO, and something else.

I mean if it's the whole group, then they can't game it. Can you write a law like that? I mean is that enough to say?

Ms. DAVIS. I certainly think that's the right concept, your issue about whether you need to write something that is kind of a general spirit of the law versus detailed legislation. It is an important issue. But certainly that would be the intent that an individual physician's compensation, or the bulk of their compensation should not directly reflect their use of, say, a hospital by patients in need of hospitalization or necessary referral to specialists.

If they're getting a share of some savings as part of a large group of physicians, where it's the actions of many different physicians with many different patients, we do not think that is of serious concern.

Chairman STARK. Then what do you do procedurally? Every lawyer in town is going to be running in and saying, does my contract meet muster? You know, they are going to want to give them a blue sky and sign off.

So, are you going to write a letter of opinions for each contract, or are you going to write some model contracts and say either use this contract or nothing?

Ms. DAVIS. I would like to call on Paul Ginsburg to talk about how he would see the combination of legislation and regulation.

Chairman STARK. Paul. What is the penalty?

Mr. GINSBURG. Excuse me?

Chairman STARK. What are the penalties?

Mr. GINSBURG. I would say the financial arrangements could be part of the process by which risk contracts are reviewed and evaluated by HCFA and approved so that a contract would either be approved in the same way that HCFA approves the quality assurance mechanism, or it could be disapproved because of certain problems and the plan would have to come back with another one.

Perhaps the approval would last as long as the contract remains the same. If the plan wanted to change the contract, it could come back to seek permission.

Chairman STARK. Would you give HCFA or whoever approves this stuff the right, if they made a mistake, to go back after they had once approved it, and say, uh, oh, something's developed we didn't see, and you've got to stop this, just like we regulated savings and loans?

Mr. GINSBURG. Well, I could see HCFA deciding that a practice that is routinely approved shouldn't be approved, and the law could give it the flexibility to change the regulations.

As for individual plans, the external review process can always identify that a particular plan has a problem and this might require changes in financial incentives, as well as in the quality assurance system.

Mr. DOWDAL. Mr. Chairman, I would like to say that I think experience has shown that if you don't have at least some specifics in that law, it's likely not to end up exactly what you anticipated when you passed it.

I know it's difficult to put in all of the things in the law that need to be there from the regulatory standpoint, but some specifics are necessary.

Chairman STARK. I understand that. But shouldn't HCFA have the ultimate decision? I mean it sounds to me like if you're going to do what Paul has suggested, then you have to give HCFA the total responsibility and not let some guy game you, or some lawyer game you into a constant appeal procedure. I know that's kind of harsh. But where it's a start-up HMO, I would assume that HCFA pretty much has that right now. They don't have to explain why they turned it down. They can just say it doesn't meet muster, and these are the areas which we don't like, and force people to redo it. Or is there a presumption that you can have an HMO if you meet certain guideposts and, therefore, we have to let them have one? I don't know what the law says now.

Mr. DOWDAL. The law requires that HMOs meet specific requirements or certain requirements. And if HCFA says they don't meet those requirements, then we don't have to give them a contract. But I presume that if the HMO disagreed, and thinks they really do meet those requirements, they could sue HCFA.

Chairman STARK. They could sue HCFA?

Mr. DOWDAL. Sure.

Chairman STARK. That's all right. HCFA doesn't have any money anyway. [Laughter.]

Well, have you all reviewed a great number of contracts? I mean have you got a bunch in hand that you poured over or your staffs have reviewed?

Paul, Karen, anybody?

Mr. GINSBURG. We've just reviewed a few examples.

Chairman STARK. Not actual competition contracts?

Mr. GINSBURG. I think these were actual contracts.

Chairman STARK. How many roughly?

Ms. CORRIGAN. Four or five. And then, in addition to that, we reviewed the findings of three major surveys that identified the particular types of compensation arrangements used by HMO's.

Chairman STARK. How about GAO?

Ms. JAGGAR. In the course of our work, we reviewed the contracts for 19 HMO's, primarily located in California, Minnesota, Florida and Pennsylvania.

Chairman STARK. Would those be pretty easy to give us an indices of causes? I mean could you do sort of a check sheet of what contracts include and don't include? In particularly, those things that you might find objectionable and those things that you might find beneficial.

Mr. DOWDAL. In effect, we have done that in the report. We have two tables in there that list——

Chairman STARK. You have it in your detailed report, I am told.

Mr. DOWDAL. Right.

Chairman STARK. Okay. Has anybody tried to write a model contract?

Ms. JAGGAR. We have not tried that, no, sir.

Chairman STARK. Dr. Davis, have you tried to write a model contract?

Ms. DAVIS. I think we have given that some thought. We certainly looked at what the arrangements are currently with the different types of HMO's with their physicians.

I think we should remember that there's still a lot of HMO's that pay their individual physicians strictly on a salary basis or fee-for-service basis.

Looking overall about 39 percent of them pay on a fee-for-service basis, 15 percent on a salary basis. At the other end, if you look strictly at the IPA model, about 43 percent of those plans pay their physicians on a capitation basis. So it varies a lot by the type of the HMO, and then within various types.

And obviously the concern is when the physician is paid on capitation. And we certainly think there is no difficulty with paying a physician on a capitation basis for primary care services, and even for them to have some incentives related to specialty referrals or hospitalizations as long as that is a minor part of their total compensation.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

Mr. Chairman, I think there is a problem here that requires a solution, but I also think that it is naive to believe that we can totally deal with this. It certainly seems reasonable to expect the management of an HMO to keep good records on the performance of individuals whether these records apply to compensation arrangements or not. And there is always the ultimate sanction of simply refusing to renew the employment contract which can hover over the head of any member of a group if it appears that they aren't following the broad principles that the HMO has in mind.

I don't know how in the world we could ultimately write something that would deal with that. That wouldn't have to do with compensation in a sense. It just has to do with whether you got the job and whether you are meeting the acceptable standards of the group with which you practice.

Having said that, I want to return to something the chairman said, the chairman used the term "model contract." I think it only fair in the end that we come up with some concept of a safe harbor

or a bright line, or the opportunity, as we do in tax rulings, to get a letter ruling and know whether you are doing it right or you're not doing it right.

I mean we've got enough uncertainties out there in this field without having to hire teams of lawyers to monitor whether a statute is being met which was written with the best of intentions, but is rather vague.

My own view is that if we cannot come up with something that is, reasonably specific and gives that assurance, I would rather extend the 1990 date and keep studying this, than to increase the uncertainty which exists today.

My old friend and fellow Cincinnatian, Potter Stuart, when faced with a definitional problem having to do with pornography, he kind of threw up his hands and said, "I know it when I see it," but I do not think that that should be our standard in something this important that deals with the quality of health care.

So, basically, my question is—Could you all help us in the relatively few weeks we have before we put a reconciliation bill together in drafting some kind of language which would provide that kind of a bright line, recognizing that there will be people out there attempting to game it, but also trying to give people an assurance that if they follow certain guidelines, they are not going to get in trouble?

We can always change the law later on prospectively if it turns out that games are being played with it. We had that experience with single premium life insurance policies, but we did not do it retroactively.

Can you help us write something?

Ms. JAGGAR. Well, Mr. Gradison, in the report that we issued in December, we have indicated four particular areas which are the ones that, in combination or singly, given their strength can make the difference and I think that perhaps the framework does exist for looking at the combinations of those various characteristics.

For example, the amount of risk, as Dr. Davis was referring to that it shifted, the length of time as Chairman Stark was referring to, the extent of the risk itself that is being shifted, and so on.

So there is a fair amount of detail, and I think the tricky part, if you will, is in making the balance between those. That is why the legislation or even regulations would be difficult, because you want to allow flexibility for a plan to do what it thinks best in its operating environment.

But I think that there is a basis for coming up with some general guidelines where if you add one plus one plus one plus one, you may have something that equals eight, which is too severe, and there may be ways to strike a balance in that regard.

We hope that our report does provide a basis for some of that already.

Ms. DAVIS. I think that I would be optimistic that one could define specific enough legislation to move forward now.

I think the approach ought to be ruling out certain types of behavior that are clearly beyond the bounds of what is acceptable, and there I think there are certain clear-cut things one could put in the law, such as, that you must have a stop loss provision, and that it would be inappropriate to pay a physician a capitation rate

that would cover all of the costs of the care of that patient, including care delivered by other physicians who are in a hospital setting.

You might want to look at the issue of giving the individual physician a financial incentive based on the performance of a group of physicians, and what should be the minimum size of such a group?

But I would rule out these egregious forms of behavior, and then the HMO is reassured that once the Health Care Financing Administration approves their contract that they are operating within the law.

So I think there are some quite specific things that one could say a plan with, or a contract with this characteristic is not acceptable, for example, a contract that does not have a stop loss and places the individual physician financially at risk for the entire spectrum of care that the beneficiary receives. One could begin with that, and then also require some disclosure to the beneficiary of what the plan's practices are. This would be an improvement over the current situation, and one could continue to monitor and do research and look at the issue over time. I think it is clear enough that this would be a positive step the Congress could certainly move forward with.

Mr. GRADISON. All right, thank you. Thank you, Mr. Chairman.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Well, I think like my colleagues and maybe even more so, because I am relatively new to this—I am trying to digest the issue.

Let me ask the chairman, if I might? Why have we not received a report from the agency?

Chairman STARK. They were ambivalent up until, I think yesterday, as to whether or not they would testify, and the report is late. It was due in January of 1988, so it would be unfair, I suppose, to blame the present Administration, because they are a little slow in coming to the table, and I do not know how far along it is. I do not suppose there is any strategy for it being late. I just think it is one of those things that has not been high on their priority list.

Mr. LEVIN. I ask that question, because I thought I might ask the panel the following question, but the record of the agency somewhat poisons the well, or affects it, but let me ask you this, and I do not mean it very critically. I have a lot of admiration for you. I am just uncertain why there is the long delay.

As I sit here listening to the testimony and to the back and forth between the chairman and the ranking member, this occurs to me that it would strike one perhaps as a matter better handled through regulation and agency action, and implementation and surveillance, than trying to embody it in legislation.

Forget for a moment about the delay in the handling of this by HCFA and the department. What would your reaction be?

Ms. DAVIS. I think that is basically on target, that the legislation could be fairly broad. As I indicated, I think there are some specific things one could rule out. But given that the situation is still evolving and we do not have any definitive evidence yet about the effects of specific types of financial arrangements, I think relying on the administrative process of approving the risk contract by the Health Care Financing Administration has a lot of merit.

Mr. DOWDAL. Again, as I was saying, I think that overall, that is the way you would want to go, having the administration prepare regulations but the particularly onerous kinds of incentive plans that exist or could exist, I think if you want to make sure that those never end up being in operation, you have to strictly prohibit them.

It takes a long time, and it is very difficult to write regulations without a specific thing in the law saying, "This is no good, and you cannot have it." If you leave it totally up to regulations, then it gets very difficult for the agency to write those regulations, get through the comments, and end up with anything that means anything in the final analysis.

Mr. LEVIN. We could indicate what we think is the potential danger and instruct the agency to issue regulations that would address these problems.

It seems to me where we have a sense of a problem without clear-cut evidence, number one, or without concrete manifestation—this is not a judicial proceeding—and number two, where we have a changing situation, right?

It seems that the forms are altering almost within our sight, and in a sense, the Congress is encouraging experimentation.

We are asking for new forms instead of just the status quo, at least as I understand the field. So for us to pretend that we can sit here sensing the problem, but unsure of its dimension, its shape in the present, and its likely shape in the future, it seems to me that is a perfect instance of the need for vigilant administrative action instead of specific legislation.

That does not mean we do nothing, or just write a completely empty blackboard. We have to put something on there that is directive, but as someone new to this, I do not quite see how we can sit here in a mark-up and write very, very specific legislation. Maybe we can, but would you feel comfortable changing places with us and going through a mark-up on this issue?

Mr. DOWDAL. I think on certain ones that are obviously pretty far out there, I would not have any problems saying in a law that those kinds of things should not——

Mr. LEVIN. OK.

Mr. DOWDAL [continuing]. Be allowed to exist, and there has been some experience with some of them in various areas——

Mr. LEVIN. All right. Just to review again quickly, if you were up here, you would prohibit what?

Mr. DOWDAL. I would prohibit shifting the HMO's risk for services, other than the physician services, to physicians, because that becomes a threat to their income. They might have to go into their own pocket and bring out the money from their other earnings to cover that, and——

Mr. LEVIN. And there are no definitional problems there?

Mr. DOWDAL. Well, I do not have any, but I am sure there are some. You know, again, the individual—things that place it on an individual——

Mr. LEVIN. So you would prohibit, in all instances, any burden on the individual under any circumstances?

Mr. DOWDAL. I think basically that individual plans are not the way to go. It just——

Mr. LEVIN. You would prohibit——

Mr. DOWDAL [continuing]. You are taking a chance, a relatively large chance, and what we were trying to say is that with a group, you have a lot more to spread risk over—it is the same principle as insurance. The law currently requires an HMO to have 5,000 members in order to get a contract. That is the insurance principle, spreading risk around.

When you place a lot of risk on one individual, that loses that concept of risk spending—you know, something terrible happens to one of your patients, you can be in deep financial trouble yourself, and that is the kind of position that I do not think we ought to be putting people into.

Mr. LEVIN. But the testimony from the Commission does not go quite that far, does it?

Ms. DAVIS. That is correct. We are equally concerned about the adverse incentives that could arise if a primary care physician was fully at risk for all of the expenses that a complicated patient incurred by seeing specialists or by going to the hospital, but we see that it might be appropriate to have some financial incentives. So that if there were some economies, some savings, that there would be some augmentation of the physician's base income.

Mr. LEVIN. But you cannot write legislation that way, though, right?

Ms. DAVIS. You could. I mean——

Mr. LEVIN. I mean, legislation is saying——

Ms. DAVIS. You are saying something like no more than 10 percent of a primary care physician's gross compensation could come from this incentive. I mean, that is quite clear in terms of statute. You could limit how much of their income was coming from the performance on the pools for specialty and hospital services.

So that is what I am talking about. You do not have to make that zero. You can limit it to, say, no more than 10 percent of their income from that type of incentive.

Mr. GINSBURG. Of course, you also have the option to just specify there should be, say, a stop loss, but allow the regulatory process to actually develop the specifics of the stop loss, and that would be fairly clear guidance to them to establish such a regulation.

Mr. LEVIN. I would think so. I mean, I think for us here to say, "10 percent," would be exceptionally difficult. It seems to me we would assume an expertise, and also a certitude, and an unchangeability that really may not be accurate.

Well, anyway, you do not have to come up here, I guess, but if you would put yourselves in our shoes on this in the days ahead.

I guess, Mr. Chairman, we have to do something or other—by what date is your review with the present cut-off?

Chairman STARK. Next April. April, 1990.

Mr. LEVIN. So it is not mandatory that we act this year?

Chairman STARK. Well, you see that April is almost gone this year, and if you think that we will be moving any more swiftly next year in the beginning of the year—it seems to me that this issue is like fresh fish, and it is not going to get any better for sitting around on our table, and we might as well get to it as soon as we can.

Mr. LEVIN. Thanks.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Well, perhaps it is because I am also a new member of the committee, but I would hope we would not move on until we have people testifying who say they have some concrete information to offer us, and not such rather slippery generalities.

I am perfectly willing to consider more concrete information, but I have a lot of questions.

In the GAO testimony in your summary, you point to a number of things that would threaten the quality of care for Medicare patients, and I look at the problems in DRG's—the problem of their failure to consider complexity, severity, frailty, some of those things, and I do not see on your list here—you talk about the number of physicians whose cost performances used to decide the incentive pool, the length of time, the risk shared, and things like that.

But in looking at protecting recipients against undue pressure on physicians to circumscribe care, and therefore, costs. I do not see anything on your list that addresses itself to looking at the pool of patients that that HMO is dealing with.

What if the pool is primarily older people? What if in that area of the country they have some high incidence of diabetes, and therefore, have complications?

I do not see on the things that you need to take into consideration any recognition of the known weakness of our current system, which is its inability to look at frailty and complexity and severity.

Ms. JAGGAR. Well, one way that that is accommodated is that the agreement that Medicare has with the individual HMO is based on a 95-percent calculation for the payment experience for the particular area——

Mrs. JOHNSON. Well, let me just stop you there a minute. But that payment experience is based on DRG's, and DRG's do not take into account these things. Is that not so?

Mr. DOWDAL. Yes, to a degree that is true, but I think what you are saying is that if we have an HMO that has a lot sicker population than the general population in the area or in the country, that would be the case where we would want to make sure that physicians did not have too much incentive to try to withhold services, rather than the other way around, if you understand what I mean?

Mrs. JOHNSON. Yes. Actually, I am looking at this both from withholding and providing. I mean, I do not know how you separate the two, because if you are going to provide penalties for over provision of services, and particularly, if they are going to come out of the guy's pocket, I think you have to look at both.

The thing is to have no factor in there. You are trying to prevent incentives from developing that will influence a physician to withhold services. You have got to take into account severity and complexity. We know that from the DRGs that that is a failing of theirs, and we have tried to respond by multiplying the categories.

But I certainly would not want to see us try to deal with this problem of incentives on the individual physician in the HMO setting where there are already pressures, without taking into account severity.

Mr. DOWDAL. Well, I think severity is primarily related to the payment issue—how much do we pay the HMO, and what we are dealing with here is, how much does the HMO pay the physician?

Mrs. JOHNSON. Yes, but it deeply affects what—how does the physician treat that case, which ends up costing, you know, and if the physician's costs are capped or in some way limited, then it is very difficult for him to respond, and if the HMO is backed-up by—well, this is the DRT.

So I think we want to be very careful before we go further in this direction to try to be sure that we address the real problem, which is eliminating an incentive for proper service, and I just do not see anything in your study that gives me any sense that you are looking to that factor, or to factor that possibility in.

Ms. DAVIS. Well, I think you are making a very good point, and that is one of the reasons we are concerned about the use of capitation payment to the individual physicians.

Say you have a physician whose patient load is disproportionately frail. Not only will those patients require a lot of his time, but those patients are going to be in and out of the hospital. They are going to need the care of an endocrinologist or other types of specialists, and therefore, if you base a lot of that individual physician's compensation on a capitation rate that does not take into account frailty, and you put that physician personally at risk for all of those referrals and all of that hospitalization, it would not be surprising if that physician did not want to take care of those frail patients.

So that is why I think the thrust of our recommendations is to look specifically at those situations where the physician is paid a fixed rate regardless of the frailty or other characteristics of the patient, and that you ought to limit the extent of physician compensation that comes from experience with regard to the use of hospital services or specialty referrals.

So I think that is very consistent with our concern about capitation——

Mrs. JOHNSON. I did not understand the last sentence of your last statement.

Ms. DAVIS. That we are concerned about the physician's individual compensation bearing too heavily on how many times beneficiaries need to go to the hospital or how many specialists they need to be referred to, because we do not have a good methodology for establishing a capitation rate that takes into account the need of the patient for these services that are beyond the control of any physician, but that——

Mrs. JOHNSON. Yes. That is good. I would like to also mention that in looking at this and elderly patients, we now have rather more experience and information, but looking at it in younger patients, there are some other things developing in their highs that I wonder if you are looking at.

Younger patients are reading more now. They are more medically literate. They are many more articles published about medical care, and more often, they are requiring—in other words, many physicians have less control over the demands side of the equation than they used to, and I do not know how we factor this in.

But since many HMO populations are young working people, we are going to have to look at, not only how do we control costs, but how do we assure that the physician is not penalized for a demand that is very real, if perhaps, not appropriate. I do not know, but that is a new factor in this equation of supply and demand that has not been there until fairly recently.

Ms. DAVIS. I think you are right that the patient today is increasingly more educated, more informed, and asking more questions, and that is why we stressed in our recommendations the importance of conducting surveys of beneficiaries, both those served in the fee-for-service setting and the HMO setting, getting information and feedback from them on problems they are having about accessibility or quality and monitoring that over time.

Mrs. JOHNSON. Dr. Davis, I have one last question that I wanted to ask you.

You recommend strengthening monitoring, watching what is happening in home care, and what I perceive as a 33 percent increase in administrative costs as a result of our effort to strengthen monitoring, which I think is absolutely appalling and unacceptable.

I need to know more. What is the monitoring now? How would you anticipate strengthening it, and would it lower or reduce administrative costs?

Ms. DAVIS. When we are talking about monitoring, we are talking about two types of things. One that is not specific to an individual HMO plan, but what is our experience with HMO's generally.

So surveying beneficiaries, for example, to see if patients are getting mammography on a regular basis, now that that is a covered benefit under the Medicare Catastrophic Plan.

But we would also recommend monitoring of the specific prepaid plans through the Office of Prepaid Health Care at the Health Care Financing Administration, and we have been looking at a variety of indicators of access and quality that we think ought to be part of that system. And whether Ms. Corrigan wants to add to that?

Ms. CORRIGAN. Yes. The Office of Prepaid Health Care, OPHC, already does conduct monitoring of HMO's. They have indicated to us that at this time their plan is—they hope—to be able to conduct onsite visits to HMO's, at least once every 2 years at a minimum.

In the past, those visits have not been conducted regularly. The monitoring activity has been a bit lax. What we are really recommending is to strengthen in that program, hopefully to improve it, and I think in addition to the monitoring activities of OPHC, there are also the PRO's that are involved in monitoring too.

So there are existing programs. it is not creating new ones, but rather to strengthen what we have.

Mrs. JOHNSON. In terms of frequency, and——

Ms. CORRIGAN. In terms of frequency and the quality of the review as well, to have established standards that have to be met by the HMO, and to——

Mrs. JOHNSON. Do we have established standards yet?

Ms. CORRIGAN. There are draft standards. I do not believe they have been approved at this time.

Mrs. JOHNSON. OK. That gives me a much clearer idea, and then just lastly, what is your evaluation of the HMO's that have gone

bankrupt from this point of view? What portion of their bankruptcy can be attributed to their inability or the fact that the physicians were not affected by, in a sense, the disincentive to deny care, which the 95 percent reimbursement rate represents and did, in fact, go ahead and provide the care they believed was necessary?

Because the assumption certainly underlying GAO's testimony, and their comments today is that physicians are sort of like Pavlov's dogs. You give them a profit, and they will do it, and you do not give them a profit, they will not.

Since I believe that physicians' decisions are governed primarily—and the earlier exchange certainly brought that forward, and a lot of this discussion does—by the fact that they must take responsibility for whether that person does well, or does not do well, or lives, or dies, and their professional reputation and standing in the community.

I think we have to look at those HMO's that went bankrupt to see whether or not the 95 percent approach ended up constraining services appropriately, or whether in fact it was unable to constrain services for whatever reasons, and then we need to know what reasons.

Ms. DAVIS. I think on the issue of bankruptcy, one key factor is just whether the HMO succeeds in reaching kind of a minimum size where they can operate efficiently. If they operate in a market where there is a lot of competition from other HMO's or people have established care patterns, it may be difficult for them to get up to a minimum size, and obviously to attract patients into an HMO, one factor is a reputation for providing good quality care.

But I do not know whether Dr. Ginsburg wants to elaborate on that.

Mr. GINSBURG. Yes, from what we have seen of studies of HMO's that have failed, there are some things that come to light.

In some cases, it has been an issue of adverse selection, that the HMO unwittingly attracted the sicker patients and was not able to manage their care for the premiums.

Other observations have been that HMO's that have failed often have not used financial incentives and often have paid physician on a fee-for-service basis and have been unable to control costs. And in some cases, the management of HMO's that have failed has been much thinner and less developed than the management in the more established, successful HMO's.

Ms. JAGGAR. Mrs. Johnson, I would respectfully like to correct the impression we may have left in your mind that we believe that HMO physicians react purely to financial incentives.

As you know, most HMO physicians are dedicated professionals with many years of experience and many of them have indeed assumed financial risk that could, under other circumstances, be considered extreme in order to provide the right kind of care to their patients.

What we are trying to suggest is that when you look across an industry, and we are not saying that we have a representative sample of HMO's, but by having looked at 19, we identified certain characteristics that make it difficult for a physician to keep straight, perhaps, in his or her mind what those priorities are under certain circumstances.

And the suggestions that we have made today, and that we make in our report, identify that there are certain circumstances whether singly or taken in combination that can put a physician under some duress.

It is not the chance to earn a profit. It is that by placing them under particular duress, you can make their priorities shift under very arduous and difficult situations where perhaps they are dealing with patients, patient groups that have, as you suggest, a severe medical condition.

Chairman STARK. Thank you. And I want to thank the panel. I just have to add one other thing.

I suspect you'll hear about it, but we do have the option, for better or for worse, and as further answer to my colleague from Michigan's inquiry—to do nothing—in which case all incentive payments would be illegal.

That is, in fact, the net result of our inaction. I'm not sure that will happen, but that's an option.

Thank you very much.

Our next witnesses comprise a panel representing the HMO industry. Representing the Group Health Association of America, Dr. Harris Berman, president of Tufts Health Plan. Representing the American Medical Care and Review Association, Dr. Michael Stocker, senior vice president of the U.S. Healthcare Systems, and representing the Kaiser Permanente Medical Care Program, Dr. Paul Lairson, the physician coordinator of the Permanente Medical Groups.

Dr. Berman, would you like to begin?

STATEMENT OF HARRIS BERMAN, M.D., PRESIDENT, TUFTS ASSOCIATED HEALTH PLAN, BOSTON, MASS., ON BEHALF OF THE GROUP HEALTH ASSOCIATION OF AMERICA, INC., ACCOMPANIED BY LESLIE ROSE, LEGISLTATIVE DIRECTOR AND MARSHA GOLD, DIRECTOR OF RESEARCH AND ANALYSIS

Dr. BERMAN. Thank you, Mr. Chairman, members of the subcommittee.

I'm Dr. Harris Berman. I'm the president and CEO of the Tufts Associated Health Plan, an independent practice association, IPA model HMO with 120,000 members based in the Boston, Massachusetts area.

Chairman STARK. Excuse me doctor. Would you care to define for us an IPA model?

Dr. BERMAN. OK. There are basically four different kinds of models of HMO's. There are staff model HMO's, group models, network models, and independent practice association models.

Let me start with them in that order to differentiate them. Staff model HMO's are HMO's that are one corporation that hires their own physicians, have their own buildings, and provide the services. So they provide both the insurance, and the provision of care directly.

Group models are two organizations. There is a health plan and a medical group and they contract with each other, sometimes exclusively, sometimes not exclusively, to provide the care for the plans patients.

In network model HMO's there is a health plan, and then a network, composed sometimes of groups, and sometimes of independent practice associations. The plan contracts with either the groups, or the independent practice associations.

In the traditional independent practice association plan, there is a plan, and there are multiple doctors who contract with the plan. The plan that I represent is a network model——

Chairman STARK. Thank you.

Dr. BERMAN [continuing]. Independent practice association. So we actually have 20 IPA's that the plan contracts with, and the plan capitates the IPA's.

In our particular case, most of the physicians draw on—are paid on a fee-for-service basis out of their IPAs' capitation. As you'll see, these arrangements are somewhat complicated—which is part of the problem.

I've practiced medicine in an HMO setting for my entire professional life, and have founded and then operated health plans—including staff models, group network models, and now an IPA model—for the past 18 years.

I'm here today on behalf of the Group Health Association of America. GHAA is the oldest, and the largest, of the trade organizations representing the managed care industry. GHAA membership serves two-thirds of the 32 million people enrolled in HMO's nationwide.

I am accompanied today by Leslie Rose, the legislative director of GHAA, and Dr. Marsha Gold, its director of research and analysis.

Mr. Chairman, we're here today to discuss the physician incentive arrangements used by HMO's, an issue you raised back in 1986, and on which you requested a study. We appreciate the opportunity to share with you our views on this subject.

Any system of compensation involves incentives. Recent studies by the GAO, and the Physician Payment Review Commission, were unable to correlate an erosion in quality of care with any specific incentive arrangements used by HMO's.

We believe, Mr. Chairman, that the physician incentive arrangements that are in place, both at the group and the individual physician level, are designed to assure appropriate utilization of services. Incentives are important for managing physician practice patterns. Only with sophisticated use of such incentives, can an HMO effectively control utilization.

In trying to assure that appropriate and high quality care is provided to HMO enrollees, we believe that physician incentive arrangements should not be considered in isolation. An HMO incentive system must be viewed in the context of the overall HMO operation, particularly, its quality assurance system. In fact, GAO points out in its report, that when considering the appropriateness of particular incentives, consideration should be given to how the incentives are counterbalanced with effective controls, such as quality assurance, utilization review programs, medical record reviews, enrollee satisfaction surveys, and enrollee grievance procedures.

GHAA has surveyed its member plans for details on their specific incentive arrangements. What we have found is a high degree of complexity and variation. Even in my own plan, we have more

than one methodology by which we pay physicians. Other witnesses, from other HMO model types, will testify as to their particular arrangements. You'll see that it is difficult to generalize about how various HMO's structure their incentive arrangements.

We are here to recommend that section 1128A of the Social Security Act be amended, to continue to permit usage of physician incentive arrangements by HMO's with Medicare contracts. We would suggest that an approach which lists prohibitions makes the most sense. To list only what is allowable would not permit innovation, and the flexibility necessary to develop new and better arrangements in the future. We want to work with you in the coming weeks to assure that whatever approach is developed, is one which can be readily administered. Development of an approach which prevents abuse, yet retains appropriate flexibility is, at best, difficult—whether dealing with managed care, or fee-for-service. We believe that HMO's should retain the flexibility to develop effective incentive arrangements which prevent overutilization, and promote high quality care.

Perhaps a proposal to establish a percentage limitation on the income at risk, in the case of individual physicians or small groups, would constitute a viable safeguard. The limit could be applied on the net gain or loss permitted on an individual physician's, or small groups' HMO income—regardless of how they are paid, whether it be by capitation, fee-for-service, or salary.

Another factor worth considering is the ability of quality assurance to serve as a counterbalance for any potential abuses. GHAA has long supported the necessity of monitoring the quality of care in all HMO's, and, for that matter, all ambulatory care. As you know, most HMO's have strong internal quality assurance programs. HMO's with Medicare and Medicaid contracts are subject to PRO/QRO review.

Mr. Chairman, let me conclude by saying that we are here to work with you, and to make sure that abusive arrangements are prohibited—in order to protect the consumer, while maintaining appropriate flexibility in the financial arrangements that HMO's can establish with their physicians.

HMO's have experienced tremendous growth over the last 10 years, and current surveys of HMO enrollees show that members have a high degree of satisfaction. You have a strong interest in controlling health care costs, while maintaining access to care. Our interest is that of an industry which wants to maintain its well-deserved reputation for high quality comprehensive benefits at a reasonable price. We need to work together, and we look forward to the opportunity to do that.

I'll be glad to answer questions.

[The statement of Dr. Harris Berman follows:]

STATEMENT OF THE GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Good morning Mr. Chairman and members of the Subcommittee. My name is Harris Berman, M.D. I am President of Tufts Associated Health Plan, an independent practice association (IPA) model HMO which has 120,000 members and is based in the Boston, Massachusetts area. I have practiced medicine in the HMO setting for my entire professional life and founded and then operated health plans for the past 18 years.

I am here today on behalf of the Group Health Association of America (GHAA). GHAA is the oldest and largest trade association representing the managed care industry. GHAA membership serves two thirds of the 32 million people enrolled in HMOs nationwide. I am accompanied today by Leslie Rose, Legislative Director of GHAA, and Dr. Marsha Gold, GHAA's Director of Research and Analysis.

Mr. Chairman, we are here today to discuss physician incentive arrangements used by HMOs -- an issue which you raised back in 1986 and on which you requested a study. We appreciate the opportunity to share with you our views on the subject.

As you are well aware, an HMO is an established health care delivery system which combines both the financing and the delivery of comprehensive health care services to members in exchange for a fixed prepayment. GHAA's 1988 Annual Survey found that all HMOs provide virtually unlimited hospital and primary care services. Eighty five percent of the HMOs surveyed provide hospital care without limits or copays. At the same time, numerous studies have shown that HMOs provide quality health care equal to, or superior, to that of the fee-for-service sector.

The managed care industry is comprised of a number of different HMO model types - group, staff, IPA and hybrids. The 1989 GHAA HMO Industry Profile, which will be released in June, found that thirty seven percent of established plans (versus 21.6 percent of new plans) have components in their plans reflecting other than their predominant model type.

The Roy/Rogers HMO Act of 1973 and the subsequent implementing regulations, mandates federally qualified HMOs to make their health services available and accessible with reasonable promptness. The statute also states that an HMO shall assume full financial risk on a prospective basis for the provision of basic health services. It permits the HMO to both share risk with physicians and health care institutions as well as make provision to limit risk, through, for example, the purchase of stop loss insurance. The federally qualified HMO is required to have an ongoing quality assurance system and regulations specifically require that an HMO "shall have effective procedures to monitor utilization and to control cost of basic and supplemental health services and to achieve utilization goals, which may include mechanisms such as risk sharing, financial incentives, or other provisions agreed to by providers."

Every system of providing services and setting compensation for the provision of such services, involves incentives. Recent studies by the General Accounting Office (GAO) and the Physician Payment Review Commission (PPRC) were unable to identify a link between an erosion in quality of care and specific physician incentive arrangements used by HMOs. We believe, Mr. Chairman, most physician incentive arrangements that are in place, both at the group and individual physician level, are designed to assure appropriate utilization of services. Physician incentives are important for managing practice patterns. Sophisticated use of such incentives has helped HMOs to better control utilization. This is important to the financial viability of the HMO and in turn helps keeps premiums reasonable and accessible.

In trying to assure that appropriate and high quality health care is provided to HMO enrollees, we believe physician incentive arrangements should not be considered in isolation. An HMO physician incentive system should be viewed in the context of the overall HMO operation, particularly, its quality assurance system. In fact, GAO points out in their report that when considering the appropriateness of particular incentives, consideration should be given to how the incentives are counter-balanced with effective controls, such as quality assurance, utilization review programs, medical record reviews, enrollee satisfaction surveys and enrollee grievance procedures.

Having said all of that, let me say at the outset, no HMO should be permitted to knowingly make a direct payment to an individual physician as inducement to reduce or limit medically necessary services provided to a specific beneficiary. Period.

GHAA has surveyed member plans for details on their specific physician incentive arrangements. What we have found is a high degree of complexity and variation typical of pluralistic health care delivery systems. Other witnesses from different HMO model types will testify as to their particular arrangements. You will see that it is difficult to generalize about how various HMOs structure their physician incentive arrangements.

We are here to recommend that section 1128A of the Social Security Act be amended to permit physician incentive arrangements to be continued to be used by HMOs with Medicare risk contracts and Medicaid contracts. We would suggest that an approach which lists prohibitions makes the most sense. To list allowable arrangements runs the risk of inadvertently excluding legitimate arrangements because of the high degree of variation and does not permit innovation, the flexibility to develop new and better arrangements in the future.

While we believe that proscription on particular arrangements is appropriate, we do want to work with you in the coming weeks to assure that the approach can be administered. Development of an approach that prevents abuse yet retains appropriate flexibility is at best difficult whether dealing with managed care or fee-for-service. We do feel certain practices should be prohibited as mentioned earlier. We also believe HMOs should have flexibility in developing their own incentive arrangements which prevent overutilization and promote high quality care. This includes individual and small group incentive arrangements. Perhaps a proposal to establish a percentage limitation of the income at risk in the case of the individual physician or small group would constitute a viable safeguard. A limit could be applied on a net loss or gain on a physician's or small group's base income for the services they provide, regardless of how they are paid - capitation, fee-for-service or salary.

Another factor worth considering is the ability of quality assurance to serve as a counter-balance for any potential abuses. GHAA has long supported the necessity of monitoring the quality of care in all HMOs and for that matter, all ambulatory care. As you know, most HMOs have strong internal quality assurance programs. HMOs with Medicare or Medicaid contracts are subject to PRO/QRO review. The Office of Prepaid Health Care (OPHC) subjects federally qualified HMOs to periodic on-site reviews to check quality and has recently decided to make such on-site inspections for each HMO every two years. Review of quality of care in HMOs is taking place - there is no parallel scrutiny of fee-for-service medicine.

Mr. Chairman, let me conclude my remarks and just say that we are here to work with you to make sure that clearly abusive arrangements are prohibited in order to protect the health care consumer while maintaining appropriate flexibility in the financial arrangements that HMOs establish with their physicians. HMOs have experienced tremendous growth over the past 10 years and current surveys of HMO enrollees show extremely high levels of satisfaction with HMO care. You have a strong interest in controlling health care costs while maintaining access to care. Our interests are that of an industry which wants to maintain our well-deserved reputation for providing high quality, comprehensive benefits for a reasonable price. We need to work together. We look forward to that effort. I'd be happy to answer any questions.

Chairman STARK. Thank you very much, Dr. Berman.
Dr. Stocker.

STATEMENT OF MICHAEL STOCKER, M.D., SENIOR VICE PRESIDENT, U.S. HEALTHCARE, SYSTEMS ON BEHALF OF THE AMERICAN MEDICAL CARE AND REVIEW ASSOCIATION

Dr. STOCKER. Mr. Chairman, and members of the subcommittee. I'm Michael Stocker and the senior vice president for U.S. Healthcare. I've been with U.S. Healthcare for 4 years. Prior to that I spent 5 years as medical director of a large staff model HMO, university affiliated, in the Midwest. I've practiced family practice for 12 years.

I'm here today representing both U.S. Healthcare and AMCRA. U.S. Healthcare is an IPA model HMO that has 1 million members in the Northeastern United States, and has 14,000 Medicare risk contract members.

American Association for Medical Care Review is a National association of some 400 managed care organizations. AMCRA's member organizations serve 15 million individuals, and include 250,000 participating physicians throughout the United States.

I, also, appreciate very much the opportunity to testify today. I would like to review three areas with the subcommittee.

The first is the reasons for the evolution of managed care, and the evolution of physician financial incentive systems. The second, is some information on U.S. Healthcare, and how it structures its incentive arrangements for physicians, and monitors the effects of incentives. The third is to discuss statutory language regarding physician incentive payments.

Everybody here, I know, is aware of the explosive costs of medical care—with 11 percent of gross national product, projected to go to 15 percent of gross national product by the year 2000. Maybe more disturbing is that the increase in the Medicare Part B costs, are at least 58 percent associated with increase in volume, and increasing intensity—as compared to increase in costs because of increase in population, and the increase in cost of prenatal services.

Everybody is seeking a way to control health care costs. Clearly, in this kind of setting the incentive arrangements that have been developed by IPA's and HMO's in general, are necessary for the appropriate containment of health care costs.

In response to this need to contain health care costs, a variety of organizations have been formed—like U.S. Healthcare. A rapidly evolving effort to reform the health care system. They have developed economic incentives that you've heard about. Various quality assurance, and utilization review mechanisms that are sometimes effective. In general, devised ways that are quite ingenious, in some cases, to better manage the care provided for patients.

A feature of many of these systems has been the use of the physician to decide whether or not a service is appropriate. I suppose nobody likes to have restrictions on medical care services that are used. On the other hand, the unnecessary use of services is not only costly, concerned this committee, but also dangerous to the patient.

We have a lot of other barriers to care in our country currently. High deductibles, high copayments that are not selective or discriminatory in determining—in deciding—how a patient's going to use services. These services deductibles, and co-payments in particular, are difficult for patients who are going to use preventive services—since they usually are services that have no symptoms for the patient.

In this setting, Medicare beneficiaries have joined risk model HMO's in large numbers. Almost 1 million people currently belong to HMO's that have Medicare risk contracts. They have done that freely, and they've done it because they prefer that to the traditional fee-for-service system.

Any payment system, whether it is fee-for-service, salary, capitation, or risk pools containing incentives, requires close monitoring. An ultimate challenge in dealing with incentive systems, is to be able to monitor and detect relatively early the inappropriate use of services.

At U.S. Healthcare we've developed a system to monitor the delivery of services in way that examines provider reactions to financial incentives. It involves an examination of each individual's practice patterns around the following parameters.

A review of referral rates to specialists and hospitals. A comparison of these rates to internal standards to detect barriers to care. Review of medical records to see if they conform to standards of medical care as determined by physician run quality assurance committees. An examination of transfers and terminations from physicians' offices. Transfer from one physician to another, and terminations from physicians' offices. A review of members who wish to leave the office, and the reasons why they wish to leave the offices.

A survey that's sent to most of the adult members of U.S. Healthcare, every year, to determine their satisfaction with their ability to see both primary care physicians, and specialists. A comparison of the results of the survey with internal standards to detect barriers to care.

This information is brought together systematically. It's reviewed monthly. Individual physicians are formally recertified on an annual basis. As part of this program we've also established a program that increases compensation to physicians for better quality of care.

Physicians who perform well on medical record audits, transfer rates between offices, member satisfaction surveys, and demonstrate proficiency in managed care, receive additional money in our compensation system. This is income that's unrelated to the utilization of services.

At this point I'd like to make a point that's often overlooked in these discussions. That is, provision of managed care, in a typical physician setting, requires not just decisions around financial issues, but also a lot of work.

For example, it is more difficult to provide care that is both cost effective and of high quality, than just to be concerned as a physician with the technical quality of care. A physician who provides care in the home, or in a nursing home, or in a short procedure unit—rather than in a hospital—finds that it is a lot more work.

The services that are provided by nurses and staff, in the hospital, are not provided by anybody else other than the physician in the other settings. Although we are all aware that those settings can provide services that's less expensive, and is also safer for the patient.

A physician who's on call late at night, who sees patients on Saturday morning or evenings, saves a lot of money from patients who would not go to the emergency room. Because they see that physician, they see the physician that has information about the patient, and their past medical record. This avoids the use of many unnecessary services that are otherwise provided with regard to an emergency room—and seen by physicians unfamiliar with the patient.

The provision of managed care is not just a decision about which is more expensive, and which is least expensive. It really involves a complicated set of decisionmaking processes by the physician. Physicians are much inclined not to withhold services. They get sued if they withhold services. Peer pressure is enormous if they withhold services. It is much easier for physicians to provide unnecessary services than to withhold the necessary services.

If we wish to promote a system that values good judgment in the management of medical care, we should provide compensation for physicians who work hard, and provide these services skillfully.

AMCRA recognizes the concern that has been expressed—the quality of care may be impacted by financial incentives. Existing statutory language was developed by this subcommittee, in response to the problems uncovered by the 1986 GAO report, which highlighted problems in certain hospitals.

Everybody's familiar with the Paraselus equivalent. We clearly think that that should be outlawed.

In response to statutory direction, extensive review has been conducted—some of which you've heard this morning. We also have reviewed the GAO report, and the PPRC report. In each of the reports they express concern about financial incentives, certainly. A concern that we share. They stressed the importance of the managed care system, and I would like to stress—and failed to identify any studies which document specific problems resulting from existing arrangements.

We share the general concern about incentives—all incentives—fee-for-service, risk arrangements. And, specifically support the subcommittee's desire, expressed in the existing statute, to prohibit cash bonus payments to physicians for limiting care to individual patients.

However, we are concerned that the existing language may be interpreted as broadly prohibiting the incentive structure—which is not only appropriate, but vitally necessary to our industry. As a result, we make three recommendations.

First, any organization which has physician incentive arrangements, should be required to have some formal quality assurance process which includes methods for monitoring, and assessing, that organization's physician incentive arrangements.

Second, incentive payments which are structured as a direct cash bonus to an individual physician to withhold or terminate a specific service from a specific patient, or that discharges specific individual patients from the hospital, should be prohibited.

This provision is not intended to prohibit capitation payments to individual physicians for physician services, or structures which induce physicians to be cost conscious through financial risk. And, incentive systems which pool an individual physician's costs for all services across broad population of patients.

Finally, Government, and the managed care community, should place a high priority on research projects to ascertain their relative impact on a variety of payment models—including fee-for-service, risk sharing arrangements, quality, cost, and so on.

Thank you, Mr. Chairman and the subcommittee. I'd be pleased to answer any questions you have.

[The statement of Dr. Michael Stocker follows:]

Statement of the
American Medical Care and Review Association
on Physician Incentive Payments
presented to the
Subcommittee on Health of the
House Committee on Ways and Means

April 25, 1989

Mr. Chairman, and members of the Subcommittee, I am Michael Stocker, M.D., Senior Vice President of U.S. Healthcare. Previously, I have served as medical director of a large staff model health maintenance organization in Chicago, and was in practice for 12 years as a family practitioner. U.S. Healthcare is an Independent Practice Association model health plan, which has been existence for 15 years, and today serves nearly one million enrollees, including 14,000 Medicare risk enrollees.

I am testifying today on behalf of the American Medical Care and Review Association (AMCRA), the national association of some 400 managed health care organizations. AMCRA member organizations serve 15 million individuals and include 250,000 participating physicians throughout the United States.

I appreciate the opportunity to testify today, and would like to review three areas with the Subcommittee:

- o The problems with the incentives under traditional fee-for-service payment models, and reasons for the evolution of managed care and revised physician financial incentive systems;
- o Information on how U.S. Healthcare structures our incentive arrangements with physicians, and monitors the effects of those incentives; and,
- o AMCRA's views of the need for revisions in the existing statutory language regarding physician incentive payments.

Problems in Fee-For-Service Medicine, and the Evolution of Managed Care

Mr. Chairman, this Subcommittee is well aware of the explosive growth in medical costs -- now consuming more than 11 percent of our gross national product, and projected to reach 15 percent by the year 2000. At the Federal level, this problem is exemplified by the growth in Medicare Part B payments. The Congressional Budget Office staff in December of last year estimated that 58 percent of the growth in Part B of Medicare from 1988 - 1990 is attributable not to price or population growth, but to the increasing volume and intensity of services provided per beneficiary.

Employers, unions, consumers, government, insurers, and health care providers throughout the United States are seeking means to alter the inflationary tendencies and lack of organized quality assurance in traditional fee-for-service medicine. Revised incentive arrangements are not only appropriate, Mr. Chairman, they are necessary for the future success of our health system. The goal is to constrain the rate of increase in spending without resorting to arbitrary limitations that would ill-serve the population at risk.

A pluralistic array of organizations, such as U.S. Healthcare, have evolved over several decades to respond to that demand, ranging from different models of health maintenance organizations and competitive medical plans to preferred provider organizations, and a variety of other arrangements being tested in this rapidly evolving effort to reform the health system. The central features of all of these plans are that they attempt to

alter the economic incentives for providers, organize quality assurance and utilization review systems, and better manage the care provided to patients.

Physicians are the appropriate focal point for the financial incentives because the physician is the best judge of the appropriate use of services. This applies not just to those services that they provide personally, but also the need for referral and hospital services, when the physician serves as the professional "gatekeeper" and care manager. We believe it most appropriate to have a physician making those decisions and managing those referral arrangements, rather than resorting to arbitrary barriers against utilization posed for patients with little or no insurance, high coinsurance and out-of-pocket costs, or an inability to wend their own way through the complexities of an uncoordinated medical care system.

Medicare beneficiaries have been able to participate in these managed care arrangements for many years through a limited number of HMOs which had cost contracts with Medicare. Effective with the TEFRA legislation enacted in 1982, participation expanded as HMOs and CMPs became able to contract for Medicare services on a prepaid basis. Today, more than 1 million Medicare beneficiaries have opted for the benefits of this model of care -- and I believe it important to stress that those beneficiaries have chosen our model instead of the more traditional, uncontrolled fee-for-service medicine.

U.S. Healthcare

Any payment system, whether it is fee-for-service, salary, capitation, or risk pools contining incentives, requires close monitoring. The ultimate challenge dealing with incentive systems is to be able to monitor and detect relatively early the inappropriate use of services.

At U.S. Healthcare, we have developed a system to monitor the delivery of services in a way that examines provider reactions to financial incentives. This involves an examination of each individual's practice patterns around the following parameters.

- A review of medical records to see if they conform to standards of medical care as determined by the physician run Quality Assurance Committee.
- A review of referral rates to specialists and hospitals, and a comparison of these rates to internal standards, to detect barriers to care.
- An examination of transfer and termination rates in physician's offices to review why members wish to leave the office.
- A systematic monitoring of grievances and inquiries that indicate that services are being withheld inappropriately.
- A survey sent to most of the adult members of U.S. Healthcare every year to determine their satisfaction with their ability to see both primary care physicians and specialists, and a comparison of the results of the survey with internal standards to detect barriers to care.

This information, is brought together systematically and reviewed monthly. Individual physicians are formally recertified on an annual basis. We have also established a program that increases compensation to physicians for better quality of care. Physicians who perform well on chart audits, transfer rates between offices, and member satisfaction surveys, and demonstrate proficiency in managed care receive additional money in our compensation system.

I would like to make a point that is sometimes overlooked when considering physician incentive systems. There needs to be a recognition that the provision of medical care that takes into account both quality and cost is more work and requires greater skill than the provision of care when the provider is only concerned with the technical quality of services provided. For example, often the equivalent or better quality of care can be provided in an outpatient setting or in the home, than is provided in the hospital. It is, though, significantly greater work for the physician to manage patients in these settings. Home care requires supervisory time from the physician that in the hospital could be provided by nurses and other staff. A physician whose office hours extend to evenings and weekends and is easily available on call, is less likely to find patients in the emergency room treated with expensive services that may not be necessary. The provision of managed care is often just more work and not only a matter of decision-making around financial issues. If we wish to promote a system that values good judgement in the management of medical care, we should provide compensation for physicians who work hard and perform these services skillfully.

U.S. Healthcare's incentive payment and quality assurance systems are but one example of the diverse arrangements found throughout the United States -- a multiplicity of arrangements that continues to evolve today. Therefore, it is necessary to carefully consider the effects of any proposed national changes in physician incentive standards.

AMCRA Views on Physician Incentive Arrangements

AMCRA recognizes the concern that has been expressed that quality of care may be impacted by financial incentives. The existing statutory language was developed by this Subcommittee in response to the problems uncovered by the 1986 GAO Report which highlighted problems in certain hospital incentive plans -- notably the Paraselsus Healthcare Corporation -- that were making cash bonus payments directly to physicians to keep each individual patient's inpatient hospital use and charges below DRG payment levels.

In response to the statutory direction, extensive review and further studies were performed by the Department of Health and Human Services, by the GAO, and by the Physician Payment Review Commission (PPRC). All have articulated their concern about incentive arrangements, but I would stress that each of them has reported on the importance of the managed care models, and have failed to identify any studies which documented specific problems resulting from the existing arrangements.

We share the general concern about any incentives -- fee-for-service and risk arrangements, and specifically support the Subcommittee's desire expressed in the existing statute to prohibit cash bonus payments to physicians for limiting care of individual patients. However, we are concerned that the existing language may be interpreted as broadly prohibiting the incentive structures which are not only appropriate but are vitally necessary -- not just in HMOs and CMPs, but throughout our health care system.

Mr. Chairman, as a result, AMCRA recommends a three-part approach to revising the existing statutory language and resolving this issue:

- First, any organization which has physician incentive arrangements should be required to have some formal quality assurance process which includes methods for monitoring and assessing that organization's physician incentive arrangements.

- Second, incentive payments which are structured as a direct cash bonus to an individual physician to withhold or terminate a specific service from a

specific patient or to discharge a specific individual patient from a hospital should be prohibited. This provision is not intended to prohibit (i) capitation payments to individual physicians for physicians' services, or (ii) structures which induce physicians to be cost conscious through financial risk and incentive systems which pool an individual physician's cost for all services or care experience across a population of patients.

- Finally, the government and managed care community should place a high priority on research projects to ascertain the relative impact of a variety of payment models, including fee-for-service and alternative risk sharing arrangements, on accessibility, quality, cost, and efficiency of patient care.

We look forward to working with the Subcommittee to resolve this issue. I would be pleased to answer any questions that you may have.

Thank-you.

Chairman STARK. Thank you very much, Dr. Stocker.
Dr. Lairson.

STATEMENT OF PAUL LAIRSON, M.D., PHYSICIAN COORDINATOR FOR THE PERMANENTE MEDICAL GROUPS, ON BEHALF OF THE KAISER PERMANENTE MEDICAL CARE PROGRAM

Dr. LAIRSON. Mr. Chairman, and members of the committee, I'm Dr. Paul Lairson, the physician coordinator for the Permanente Medical Groups, testifying on behalf of the Kaiser Permanente Medical Care Program.

Kaiser Permanente is a pre-paid group practice health care delivery system that organizes and provides comprehensive care to more than 5.9 million voluntarily enrolled members, in 12 regions, serving 16 States, and the District of Columbia. We presently have 150,000 Medicare risk contract members.

The program has pioneered many features. Such as, comprehensive benefits, quality based on organized systems with peer review, various cost control methodologies, and dual and multiple choice options for consumers.

This presentation emphasizes the following points. First, amendments to section 1128A of the Social Security Act are necessary to protect legitimate physician incentive compensation arrangements used by Medicare risk contractors.

Two, the preferable approach to amending the statute is to specify those arrangements which are prohibited.

Three, arrangements which reward individual physicians for reducing services to specific patients are inappropriate, and Congress should continue to prohibit them.

Four, under Kaiser Permanente's physician compensation arrangements, capitation arrangements are made to the medical groups. Individual physicians receive salaries from the medical groups. Risk compensation represents a very small portion of each physician's compensation and is based on each operating region's results—not upon individual performance.

Five, Kaiser Permanente's physician compensation arrangements are an important contributor to the program's success.

Effective April 1, 1990, Medicare risk contractors will be prohibited by the provisions of section 1128A of the Social Security Act, from making direct or indirect incentive payments to physicians or hospitals to reduce or to limit services. Congressional intent was to protect Medicare beneficiaries from arrangements that could create strong incentives for providers to withhold necessary services. This is certainly appropriate. However, the statutory language is so broad that it would jeopardize a number of legitimate payment arrangements used by Medicare risk contractors, including those used by Kaiser Permanente.

In addressing how to modify this statute, we strongly recommend that it be amended to specify those arrangements that would be prohibited, rather than those that would be permitted. Such an approach is preferable because it recognizes that compensation arrangements will change in the future as circumstances change. It would be impossible to anticipate all future desirable arrangements.

This committee is considering the question of what types of compensation arrangements should be prohibited under Medicare risk contracts. We share the concern expressed by others about payment incentives paid over a short period of time to individual physicians for the purpose of reducing or limiting treatment to specific patients. However, we do not know of any studies that address the patient outcomes resulting from these arrangements.

Kaiser Permanente does not have expertise in all forms of physician compensation incentives, and we are not aware of all of the arrangements used by Medicare risk contractors. However, I will describe for you the physician incentive compensation arrangements that we use in the Kaiser Permanente program. They are essential to the continued successful operation of our program, and should be preserved by any statute addressing this issue.

Persons enrolled in our program as members through Kaiser Foundation Health Plan Inc., or one of its 11 subsidiaries. Health plan, in each region, contracts with an independent Permanente medical group, which accepts regional responsibility for professional care of health plan members. We have 12 regions, and 12 independent Permanente medical groups. The amounts paid to each medical group, by health plan, are negotiated annually. The Permanente medical group derives over 95 percent of its professional income from health plan, for serving health plan members. Revenue received by the medical groups for Medicare risk contract members is indistinguishable from revenue received on behalf of any other member in the program.

The primary payment by health plan to medical groups in each region is a per capita payment. An agreed upon amount per member, per month, that does not vary with the volume of services. The per capita payment provides over 90 percent of Permanente physician compensation.

In addition, a portion of each medical group's agreed upon compensation is withheld, and is at risk. This at risk compensation is paid only if health plan's financial results meet forecast. The amount of any variance from forecast in health plan's financial results, positive or negative, is shared by both health plan and the medical group—except the amounts of the negative variance borne by the medical group, cannot exceed plan at risk compensation. Finally, compensation is adjusted under a corridor arrangement that reduces the medical group's risk of loss, and opportunity for gain. At risk compensation may not exceed 10 percent of the medical group's compensation—by contract. However, as a practical matter, this limit is not approached. For the last several years, at risk compensation has averaged about 4 percent of total physician compensation.

The compensation arrangements that I have described apply in our mature, economically self-sustaining regions. In some newer regions, the medical groups are, in substance, reimbursed for their costs directly by health plan.

Permanente physicians are compensated directly by the 12 Permanente medical groups, which are independent, and therefore, can and do, have variations in their compensation arrangements. However, they have similar patterns in distribution of medical group income. Permanente physicians are not compensated on a

fee-for-service basis. Rather, income is pooled, and distributed under a prearranged formula that does not relate income to specific services provided.

By altering the straight line relationship between services performed and income received, the program's compensation arrangements encourage provision of the most appropriate services to health plan members.

The natural consequence of this approach, combined with comprehensive pre-paid benefits, is emphasis upon preventive care and early detection of illness.

Permanente physicians are salaried in all regions except our Southern California region, where the medical group is a partnership, and partners technically receive a draw. Salary increases are not tied to utilization in any region. All medical groups establish salaries for each physician when hired, according to medical specialty and other qualifications—including training, experience, and board certification.

Salary increases for physicians are based on performance evaluations, and length of service. Physicians' evaluations are based upon a variety of criteria, including, for example, quality of care and service provided, relationships with patients, relationships with colleagues and employees, professional attitude, confidence, technical skills, medical knowledge, clinical judgment, punctuality, willingness to assume additional work, understanding of the group practice arrangement, community activities, and the use of the physician's educational time.

All compensation systems, whether in a fee-for-service, or prepaid group practice, could create incentives. Our compensation arrangements reflect an attempt to establish incentives for physicians to provide medically appropriate care.

While health plan is at risk to provide a comprehensive set of prepaid services for our enrollees, physicians primarily determine what health care services should, and will be, provided to our enrollees. Thus, the success of our program is closely related to the manner in which the Permanente medical groups assume risk, and responsibility, for the success and survival of the entire program.

The arrangements under which Permanente physicians are compensated are not the only factors in creating a strong sense of physician responsibility for, and commitment to our mission—which is to provide cost-effective quality care to our members. However, we believe our compensation system has been instrumental in the success of our program.

Thank you for the opportunity of testifying on this important issue. I'll be happy to respond to any questions.

Chairman STARK. Thank you, doctor.

I think it's important. Some of the members have asked about this, the way this all came about. Back in 1985–86 the one particular arrangement was this Paraselus Health Care Corp. which, basically, was paying the doctors every month based on what they could save under the Medicare risk payments.

In other words, if you kept people out of the hospital for a month, you got an extra payment that month. I am sure that that may very well have been a unique situation. I certainly hope it was. However, in trying to find a way to prevent that from happen-

ing again—the guy who ran Paraselus is probably not in jail, he's just in Germany. That's the problem.

Somebody says if ain't broke, don't fix it. Well, it was broke once. We're just trying to figure out a way to prevent that from happening again.

I might ask Dr. Lairson, just as a matter of some personal interest, when he thinks Kaiser may be signing Medicare risk contracts in northern California.

Dr. LAIRSON. As you know, Mr. Chairman, we have risk contracts in 10 of our 12 regions. northern California does not. As a matter of fact, northern California is considering the risk contract again, at this time.

One of the reasons for not having a risk contract in Northern California has been the concern over the ability to provide services to an influx of new, older members, creates. This has created problems for our medical groups in some of our other regions—having enough physicians, facilities, et cetera, to provide the services. And, as you probably know, we have experienced unusually large growth in the last year or so. That is also a factor in that equation.

Chairman STARK. I just wanted you to know my mother hasn't smoked in 2 years—if that makes any difference. [Laughter.]

Dr. LAIRSON. Neither has mine.

Chairman STARK [continuing]. In coming to that decision.

Mr. Gradison.

Mr. GRADISON. No questions.

Chairman STARK. Mr. Levin.

Mr. LEVIN. No.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. No questions.

Chairman STARK. I guess that in hearing what you are saying, you say prohibit those practices or those sorts of things which we find objectionable. I think that is fair to ask.

But, again in the creative environment in which we exist, I am just always afraid again that without some broad statement and an ability to review these contracts, that we just create a bunch of targets for very bright contract lawyers to get around or shoot down.

I think we will have to have a combination of both. We've stewed on this for awhile, and it's been studied. I understand that the Administration's report is in fact completed, but languishes for lack of approval from whomever has to approve its release. I don't have the foggiest idea what's in it.

That may shed some light, but I doubt it. I don't know how many different anecdotes people can dream of. We are just going to have to sit down and hammer this out. And I would hope that we could get some assistance from you gentlemen or your industry. It might be that we are just going to have to review a lot of contracts and say these pass muster under some general broad guidelines and have a method to come back and review it fairly quickly after the first regulations are implemented on the theory that we will overlook someone, or someone will dream up something that we didn't anticipate.

I suspect that well-intentioned people will have no problem identifying those practices which seem to be improper or unethical or disadvantage the patient or the Government. I am saying we are at

a loss as to how to write them. And I hope you will continue to help us.

Mr. Pickle, did you wish to inquire of the panel?

Mr. PICKLE. Mr. Chairman, I've got an awful lot to learn about these HMO's and their practices. I don't believe we've got enough information at this point from the proper agencies to make a recommendation to us.

Mr. Levin may be right that we ought to look at this in terms of regulation more than passing a statute.

It seems to me like when we talk about incentives, we can more probably say they are a threat, or they are just a hammer hanging over a doctor's head rather than an incentive. It's a negative incentive at best.

And until I get a report from HCFA, I am going to kind of withhold judgment on how we are going to do this. I don't know why HCFA is so late. They are a year behind on this. But when we get this information, I think it will be helpful to us.

In all this, let me ask you, how do the physicians feel about this? Do they think they ought to have no incentives, or should we change the law, should we legislate on it, or do they complain to you, or what are their comments? What reaction do we get from physicians about this approach?

Who wants to comment on that?

Dr. STOCKER. If I can, I would distinguish now between physicians who are involved in management, like ourselves, and physicians who primarily are involved in the practice of medicine. If I could take a shot at paraphrasing their feelings.

I would think—I want to stress this—it is an unusual physician, although it happens, that will withhold services that are necessary. On the other hand, they want to be compensated for the legitimate work that they do. And the manage/care programs in the name of economies ask them to do a number of things that are really more trouble for them.

For example, if there's two equivalent hospitals, and both of the hospitals are of equivalent quality but we have a contract with one hospital and we don't with the other hospital, we may ask the physicians to get on staff of that hospital. That's more trouble for the physicians.

We ask physicians to be more available than they traditionally are in fee-for-service practice. Because if they are available, it means that they can take care of patients in a more economical manner in addition to being more satisfying to the patient.

Patients stay with plans, health care plans, where physicians are available to the patients at nights and on weekends and so, more than plans where physicians aren't available.

So, in the end, they see this as more work, more supervision, and they don't see it in the terms that we're talking about where they are concerned about withholding services in the main because of the incentives, and they want to get paid for the legitimate work that they do.

Mr. PICKLE. Well, are physicians happy with the practice that you have? Are you getting just the younger people or are you getting someone who is more established, and do most have just a certain percentage of HMO? Who constitutes your physician groups?

Dr. STOCKER. About currently about 60 percent of all physicians in the country belong to some kind of managed care organization. So you are talking about a system that really involves most of the physicians in the country. It varies a little bit. They may not have all their patients in managed care. And it varies a little bit by specialty.

So, in the main, you are looking at a cross-section of physicians in the country.

U.S. Healthcare, for example, has 10,000 specialists that we contract with for services in six States. I can't but believe that that's just a pretty good cross-section of doctors in those six States.

Dr. LAIRSON. We have in the Permanente Medical Group almost 7,000 physicians nationwide. It used to be that most of our physicians came directly out of residency training or out of the military. More and more, we are recruiting physicians who are in a fee-for-service setting where they feel pressured to join multiple kinds of managed care systems which have different incentive arrangements. And they view this as being more control and, therefore, they looking for a different practice environment. And we find that we get more and more of our physicians from that group.

There is generally a lot of confusion, I think, among physicians about what all of this means, these managed care organizations with the different financial arrangements and incentives.

Mr. PICKLE. Well, it would seem to me that we should receive some comment from the physicians who actually give the services.

I hear testimony from you, the health care people, the GAO, maybe from HCFA eventually. But the person who delivers the medicine and the care is the physician. And I am just wondering how he views these "incentives" which are negative incentives, and whether he thinks we ought to have legislation on it.

And I guess you are reluctant to speak for the physicians, or are you willing to say that they approve these changes or not?

Dr. LAIRSON. I believe in general, fee-for-service physicians in this country would rather not have anything change and continue to practice medicine the way they always have.

Mr. PICKLE. And you're saying that we should have changes. But I noticed all of you saying we should be very careful in changing, be guarded about it. And I don't know what that means.

Dr. LAIRSON. I'm not sure we would totally agree on what that means, Mr. Pickle. But there's a difference. There are some things that we view as offering too much of an incentive to physicians individually to do the wrong thing.

On the other end of the scale, we don't want to be so restrictive that we stop innovation in trying to get control over health care costs. There is a middle ground in which I think that on which the three of us would certainly have agreement, and with which most physicians would agree.

Mr. PICKLE. All right. Thank you, Mr. Chairman.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

I just wonder if there's any evidence of withholding care? How clear is the evidence that there is care being withheld?

Dr. BERMAN. I think that there's been no evidence presented that there is care being withheld. In both the GAO and the Physician

Payment Review Commission reports, they did not find any evidence of that.

Mrs. JOHNSON. Thank you. That's been my impression. Thank you.

Dr. LAIRSON. I think there's been some evidence that perhaps the place of care has shifted from hospitals to outpatient settings and so forth, but not that care has been withheld.

Mr. PICKLE. Mr. Chairman, you mean we don't have any examples, specific examples of how this present practice is being abused? Have we had any testimony or is it just something somebody thinks that it might be abused?

Chairman STARK. Mr. Pickle, we have indeed had some examples of serious abuse. I'll give you the GAO report here which details them. And in attempting to change the law to prohibit that abuse from reoccurring, we come to our present dilemma.

I think there's great agreement among all the parties of this as to what we ought to do, what's bad and what's good. It's defining a duck.

But, in writing the law, that's where we come a cropper. So it's something that we have to get done. We have to write the law and see what the regulations might be and see how it works. It's tricky and nobody has the solution. If you get too many letters in the law, the spirit of the law gets all jumbled.

I'll be glad to share with you the items in the GAO report that point out——

Mr. PICKLE. Well, I think if we have examples where physicians have actually abused the privilege of their practice——

Chairman STARK. I'm not so sure that physicians have, but the people running the HMO.

Mr. PICKLE. On the program?

Chairman STARK. Yes. And we're putting forth inappropriate incentives.

Mr. PICKLE. It affects quality care. Then, of course, we ought to look into it. But I just would like to see more of these specific examples on what is actually happening out there before I start "legislating."

Chairman STARK. Well, the distinguished gentleman from Texas is in the same position I am. If we don't legislate, the hammer drops, and no incentive programs will be able to be formulated after next year.

So we are in a position where we have to propose the present law meaning that incentive contracts of any type would become illegal. So, now, we have got to say, okay, what types will be legal? I think that this committee and the industry and the Administration will be able to work together and work that out as best we can.

If there are no other inquiries of the panel, I want to thank them and reiterate that we have got our work cut out for us for the next year. And I look forward to your assistance as we try to get this resolved.

Thank you very much. The committee will stand in recess.

[Whereupon, at 11:53 a.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Blue Cross and Blue Shield Association is pleased to submit this statement for the record of the subcommittee's April 25 hearing on physician incentive payments by prepaid health plans. Under current law, health maintenance organization (HMOs) with Medicare contracts will be prohibited from making incentive payments to physicians, effective April 1, 1990.

Seventeen Blue Cross and Blue Shield Plan HMOs currently provide health care services to 108,000 Medicare beneficiaries under risk and cost contracts with the Health Care Financing Administration.

Blue Cross and Blue Shield Plans also sponsor another 78 HMOs that do not hold Medicare HMO contracts. In total, our 95 HMOs serve a private sector enrollment of approximately 5 million members. These HMOs represent a major potential for expanding the Medicare HMO program.

In our statement, we will provide the subcommittee with;

- Data on the nature and scope of physician financial payment arrangements in Blue Cross and Blue Shield Plan HMOs, and
- Recommendations on legislative changes to OBRA-86 which currently prohibits all forms of physician incentive payments for HMOs participating in the Medicare program.

Payment Arrangements with Physicians in Blue Cross and Blue Shield Plan HMOs

In 1987, the Blue Cross and Blue Shield Association conducted a survey of the physician incentive arrangements in our HMOs. At the time of the survey, we had 107 HMOs with a combined enrollment of 4.2 million members. This represents a market share of about 15 percent of total HMO industry enrollment.

Our survey found that the vast majority (87 percent) of Blue Cross and Blue Shield Plan HMOs use some type of physician incentive arrangement. More specifically:

- 78% of responding Plan HMOs use capitation (alone or in combination with other payment arrangements) for primary care services.
- 65% employ withhold arrangements whereby a portion of the physician or medical group's payments are withheld against the risk of over-utilization. The withhold range as a percent of capitation or fee-for-service payments was between 10 to 30 percent.
- 34% of Plan HMOs employed some form of individual performance incentive. The most common form of individual incentive arrangement is a "mixed incentive arrangement". Individual physicians are paid a fixed (capitated) fee for primary care services. A portion of this fee is withheld to guard against the over-utilization of specialty and hospital services. If the individual physician's experience for their patients in the aggregate is equal to or below projected actuarial targets for the entire HMO's enrollment, withhold funds are returned regardless of how other physician and the HMO as a whole perform. Also, if the HMO has year-end surpluses, these surpluses are shared with those physicians whose performance is under target.
- 92% of Plan HMOs have stop-loss provisions to limit inappropriate and catastrophic risk (e.g., a limit on the maximum dollar risk per enrollee).

We believe that incentive arrangements are important in focusing physician attention on the cost effectiveness of the care they deliver. Indeed, the success of many HMOs in managing health cost utilization is dependent in large part on the preventive care focus of the HMO and the

incentive arrangements they have made with HMO physicians. Moreover, studies show no systematic problems with the quality of care rendered to HMO enrollees. An independent survey of Blue Cross and Blue Shield Plan HMO members show that the vast majority -- 95 percent -- are satisfied with the care they receive.

We also believe it is important to note that physician behavior is influenced by a number of factors other than the compensation arrangement employed by the HMO. Additional factors influencing behavior include professional standards, malpractice, peer review, HMO utilization review and quality assurance programs.

Legislative Recommendations

If the current prohibition under Medicare of HMO incentive arrangements with physicians becomes effective in April 1990, the majority of the 17 Blue Cross and Blue Shield Plan HMOs currently participating in the Medicare HMO program would be unable to continue to serve Medicare beneficiaries without major change in their HMO/physician contractual arrangements. Moreover, this prohibition would discourage most other Plan HMOs from seeking Medicare risk contracts. We therefore urge the subcommittee to take action this year to amend the current law to specifically prohibit only those HMO physician incentive arrangements that have a clear and direct linkage to the under-provision of care to HMO members.

To provide the HMO industry with a reasonable degree of certainty concerning which arrangements will be permitted under Medicare, we are recommending that the law not establish limited exceptions to a general prohibition on incentive arrangements, but instead specify which arrangements are prohibited. This would establish a "bright line" that would provide HMO managers with assurance that arrangements not falling into the prohibited category will be acceptable for purposes of Medicare risk contracts.

The specific type of individual physician incentive arrangement that we recommend be prohibited by law is one in which the physician's compensation is directly tied to treatment decisions made for an individual patient. Concern over such an arrangement employed by a hospital was the original basis for the 1986 prohibition legislation. This prohibition should not, however, preclude the use of incentive arrangements based on an individual physician's aggregate performance over all the HMO patients he or she treats.

We share the subcommittee's concern that "too much" risk should not be placed on HMO physicians participating in the Medicare program. We recommend that Medicare HMOs be permitted to continue to employ individual incentive arrangements provided that the physician's or medical group's potential loss or gain is limited to a fixed percentage of base compensation. For example, the law could prohibit HMOs from entering into Medicare contracts if its compensation arrangement puts physicians or groups at risk for more than 30 percent of the base capitation payment. We believe that such a standard should apply universally to all types of incentive arrangements, not just individual-based arrangements.

Stop-loss insurance to protect individual physicians and small groups of physicians against significant financial loss for catastrophic care also is an important element in designing a reasonable and responsible capitation arrangement. We therefore recommend that the legislation prohibit capitation arrangements where the capitated patient population is small (e.g., less than 100 patients) unless the individual physician or small group of physicians is provided with stop-loss coverage at levels consistent with industry standards.

Finally, we believe that the actual effect of any financial incentive arrangement on HMO patient care can only be determined through a formal quality assessment program. HMOs with Medicare contracts currently are subject to quality review by Peer Review Organizations and on-site quality inspection by HCFA staff. Quality review efforts can be focused, if necessary, on organizations employing individual physician incentive arrangements as an adjunct to the percentage limitations on risk and stop-loss provisions we have suggested.

Conclusion

In conclusion, we share the subcommittee's concern that Medicare beneficiaries enrolled in HMOs not be denied access to needed care because of the perverse incentives of a financial arrangement between the HMO and the beneficiary's physician. We stand ready to assist the subcommittee in the difficult task of developing legislation to prohibit those financial arrangements that have a high potential for abuse.

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TESTIMONY

of

The Coalition to Preserve Quality Care

on behalf of the following Coalition Member Organizations

American Academy of Dermatology
American Academy of Otolaryngology, Head and Neck Surgery
American Association of Clinical Urologists
American Gastroenterological Association
American Neurological Association
American Physical Therapy Association
American Pophyria Foundation
American Psychiatric Association
American Psychological Association
American Society for Gastrointestinal Endoscopy
American Society of Hematology
American Urological Association
Ehlers Danlos National Foundation
Foundation for Ichthyosis and Related Skin Types
Joint Council of Allergy and Immunology
Lupus Foundation of America
National Foundation for Ectodermal Dysplasias
National Vitiligo Foundation

Submitted To The

Health Subcommittee, House Ways and Means

Committee

Relating To

Physician Incentive Payments By

Prepaid Health Plans

for the Hearing Record

of April 25, 1989

PHYSICIAN INCENTIVE ARRANGEMENTS

There is general agreement that neither overutilization nor underutilization of health care services constitute acceptable patterns of practice and that either may reduce the quality of care. Furthermore, while overutilization clearly increases the cost of care, underutilization likewise, rather than reducing expenditures, has the potential for escalating costs in the long run if, by virtue of ill-advised parsimony, diseases which are initially curable are allowed to progress to become chronic and incurable.

The fee-for-service system has been faulted because it may tend to encourage the overutilization of services. Much has been written about geographic variations in the level of services provided and the implications this may have for inappropriate utilization patterns. While there is much that remains to be clarified about such data, there is clearly a need to develop more appropriate guidelines of practice and this process is well underway with the support and encouragement of a number of national medical organizations.

With the rapid growth of prepaid managed-care systems of health care delivery, a new phenomenon has emerged as a source of concern to many physicians and health policy analysts because such systems, by their very nature, provide a significant potential for underutilization of services and, hence, reduced quality of care. The fact that HMOs and other managed care organizations are now subject to peer review attests to the increasing concern about this issue.

One aspect of managed-care systems which has generated particular concern is the widespread imposition of various types of physician incentive arrangements by the creators of these systems as a method to control and reduce the level of services. Because such incentives have the potential for influencing professional judgement, they may create situations where there is a conflict of interest between patient and physician. Concern about the inappropriateness of some physician incentive arrangements is reflected in the prohibition of such arrangements in the Omnibus Budget Reconciliation Act of 1986 which also called for a study of the scope and nature of the various physician incentive arrangements currently in use. This concern is also responsible for independent analyses of the issue which have been undertaken by the General Accounting Office, the Physician Payment Review Commission and the Institute of Medicine. Furthermore, several very excellent articles summarizing the potential consequences of physician incentive arrangements have appeared recently.[1,2]

Clearly, the concept of managed care implies that the physician will exercise discretion and fiscal conservatism in the provision of diagnostic, consultative and therapeutic services. It is probable that most physicians who are serving as gatekeepers in managed care systems are well-intentioned and perform their dual function as patient advocates and fiscal conservatives well, though there is evidence that the ambivalence of their position is disconcerting to some. There is, however, an inherent tension created by administrative systems which encourage overly zealous parsimony in the provision of services as a method to improve the profitability or the competitive position of the system. The question to be addressed is whether physician incentive arrangements provide a serious potential for altering this delicate

balance in which in physician serves a dual function. If the professional judgement of the physician is undermined or subverted by monetary or other rewards so that needed services are withheld, not only may the patient suffer, but in the long run the system may incur additional costs down the road because disorders which may be correctable in the early stages are not recognized until they have become incurable.

There are various patterns of physician incentive arrangements which can be readily identified.[1] It is possible that some of these patterns, with appropriate safeguards may be acceptable while others may not be because the possibilities for abuse are too flagrant and safeguards would be impossible or can be predicted to be inadequate.

This essay will identify the basic patterns of physician incentive arrangements, suggest those which are either acceptable or unacceptable and propose appropriate safeguards for those which are acceptable.

I. Patterns of Physician Incentive Arrangements

While there is much diversity in the types of physician incentive arrangements in prepaid managed care systems, three basic patterns, or categories, emerge.

A. Bonus Arrangements

Physicians who are not otherwise at financial risk for referral to specialists, utilization of laboratory or other ancillary services, hospitalization or prescription medications may be offered bonuses if they adhere to certain targeted levels for such services. The bonuses may be even higher if they fall below the targeted thresholds. Such bonuses are usually financial but conceivably may be non-financial (i.e. promotion, vacation options, travel incentives or various types of perquisites). Such incentives may be granted either to physician-gatekeepers or to both physician-gatekeepers and to specialists. It is also possible that in some instances such bonus arrangements may include non-physician health care providers who are responsible for patient care (i.e. physicians assistants, nurse practitioners, etc.) although we have no information about this.

B. Capitated Systems With or Without Risk Sharing Arrangements

In many capitated prepaid managed-care systems a portion of the capitation fee is withheld and placed in one or more risk pools from which referral fees, laboratory and other ancillary services, prescription medications and even, at times, hospitalization costs are paid. At specified intervals any surpluses remaining in the risk pool are rebated to the capitated physicians. Such systems provide a clear financial incentive for the physician to underutilize such services. Some capitated systems may not impose shared financial responsibility for utilization of such services through risk pools. While there may not be a financial incentive or disincentive in such systems, there is still some potential for underutilization of the physicians own services through inappropriately

reduced scheduling of return visits, shortened time per visit or use of therapeutic modalities which are less costly, and possibly less appropriate as well.

C. For-Profit Managed Care Systems with Physician-Investors

With the growth of for-profit managed care systems many prepaid systems now are owned solely, or in part, by physician-investors. Clearly, the financial viability and profitability of these systems becomes a matter of financial interest to the physician-investor and may thus provide a conflict of interest between what is advantageous to the patient and what is advantageous to the physician-investor. Again the potential for underutilization of services as a mechanism to encourage profitability becomes an issue of concern.

II. Are there Acceptable Patterns of Physician Incentive Arrangements?

While theoretically any type of physician incentive arrangement provides a conflict of interest which may reduce the quality of care, practicality dictates that some types of arrangements may be so well established and ingrained that they may have to be retained. The challenge then becomes to identify those types of arrangements which are so fraught with potential for abuse that they should be prohibited and those which may be acceptable with appropriate safeguards incorporated to protect the patient's interests. In this section we will attempt to separate these types and propose appropriate safeguards.

A. Bonus Arrangements

It would appear that bonus arrangements, both financial and nonfinancial, provide the most serious potential for flagrant abuse of the system. Such arrangements provide a clear linkage in the mind of the participating physician between the withholding of service, or the use of less expensive and, possibly, inappropriate services, and financial or other rewards. Such arrangements should be expressly prohibited for any prepaid managed care system regardless of the acronym by which it is designated (i.e. HMO, IPA, PPO, SHMO, etc.). Furthermore, such prohibitions should apply not only to financial incentives but to non-financial incentives as well and should apply to non-physician health care providers as well as to physicians.

B. Capitated Systems

1. With Risk-Sharing Arrangements

As in the case of bonus arrangements, the potential for abuse of such arrangements is very strong. In effect, such arrangements differ little from bonus plans and the linkage between utilization and reward is very strong when the capitated physician must, in effect, pay for the ancillary and referral services out of his or her own pocket. Under such circumstances the temptation to withhold, or underutilize, needed services might become very compelling. This is true

whether the physician is a gatekeeper or a capitated referral specialist. Such arrangements should also be expressly prohibited.

2. Without Risk-Sharing Arrangements

When the capitated physician is responsible only for the care given personally to the patient and assumes no significant financial risk for the use of ancillary or referral services, it seems reasonable to permit such an arrangement. It is in this circumstance that effective utilization review and peer pressure can be implemented to identify and modify the utilization patterns of those who persistently demonstrate inappropriate deviations in their practice patterns. Since no financial incentive or disincentive is offered, objectivity can be established and persuasion exercised in a neutral environment. Furthermore, it is in such a neutral milieu that peer review will be able to function most effectively to ensure the quality of care.

C. For-Profit Managed Care Systems with Physician-Investors

As noted above, the potential for conflict of interest in such systems is clearly apparent since funds not expended become profit. One must question the inherent wisdom of allowing the growth of such systems but it is probably unrealistic to suppose the physicians would be required to divest themselves of ownership of managed care systems at this late time. There is also a positive aspect to physician ownership since it provides some degree of self-determination by those who are committed to serving as the patient advocate.

Assuming then that physician-investor systems will persist are there appropriate safeguards which could be incorporated to protect the patient's interests? It is here that peer review by P.R.O. or comparable organizations must be imposed to carefully monitor utilization patterns of ancillary and referral services. This process of peer review should compare patterns both within the system between physician-investors and physician non-investors and also between for-profit physician-investor owned systems and those which are not physician-investor owned. Those physicians who have a financial stake in the managed care system must be specifically identified as well as the level of their investment. If it becomes apparent that the physician-investor is inappropriately underutilizing services, that individual should be required to modify the inappropriate behavior, divest or resign. Furthermore, patients enrolled in such systems should be clearly informed of the financial stake of the physicians in such a system and the serious implications which such ownership may have for their level of care.

III. Additional Safeguards

The fact that managed care systems are now subject to peer review is a major step in the right direction and one that is long overdue. This provides

an important safeguard against the zealotry with which some managers of such systems, who pursue balance sheet-oriented health care, seem to be imbued and, hopefully, will serve to protect the rights of both patients and physicians. However, such review does not justify the continuation of system structures which, by offering inappropriate physician incentives, are inherently unwise and inappropriate, and which, therefore, invite abuse of the system.

There are several additional safeguards which should be imposed upon all managed care systems as follows:

A. Patient Information

Just as it was important for individuals who borrow money to be aware of the actual facts about the interest they must pay which prompted the truth-in-lending legislation some years ago, so also it is important for patients enrolled in managed care systems to be aware of the fact that such systems are designed to provide some limitations on the care they receive.[2] We are not certain that such limitations are always explained carefully to potential enrollees. This would be particularly important in the case of any type of incentive arrangement which might be allowed. There is thus a need for clear presentation of limitations which will be imposed, their potential implications and the possibility of conflict of interest of any type of incentive arrangement permitted.

B. Ombudsman

We believe it would be highly desirable for all managed care systems to have an independent ombudsman to whom both patients and physicians would have access when there is some question about limitations on care which seem inappropriate. This should be available on a completely confidential basis so that neither patient nor physician would incur any penalty for "whistle blowing".

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